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: 150046	Period: From 09/01/2015 To 08/31/2016	Worksheet S Parts I-III Date/Time Prepared: 1/26/2017 11:15 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 1/26/2017 Time: 11:15 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

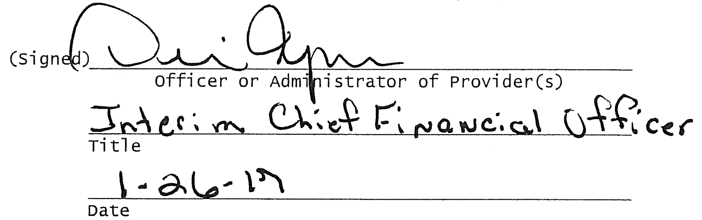
PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by TERRE HAUTE REGIONAL HOSPITAL (150046) for the cost reporting period beginning 09/01/2015 and ending 08/31/2016 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.

Encryption Information
ECR: Date: 1/26/2017 Time: 11:15 am
5.hkXn82bpz3tDzD5atzRXbtsn26o0
GAZMg0R.w3n08MSPUMK0UtPK6DBVP.
7Zss1gkNYI0Qne1V
PI: Date: 1/26/2017 Time: 11:15 am
N12iLMjXmFXWWLb1pSmPtN:1yUX7g0
Mco1P0cAWUGvHelGIIxJMDLOybm4yH
FKtv00slxV0PWWWR



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

Interim Chief Financial Officer
Title

1-26-17
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-71,485	45,540	0	2,615,346	1.00
2.00	Subprovider - IPF	0	33,867	-139		456,703	2.00
3.00	Subprovider - IRF	0	59,410	-115		144,989	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	21,792	45,286	0	3,217,038	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.

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: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S Parts I-III | Date/Time Prepared: 1/26/2017 11:15 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report   Date: 1/26/2017   Time: 11:15 am
2. [   ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
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7. Contractor No.
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10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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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 TERRE HAUTE REGIONAL HOSPITAL (150046) for the cost reporting period beginning 09/01/2015 and ending 08/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

____
Title

____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-71,485	45,540	0	2,615,346	1.00
2.00	Subprovider - IPF	0	33,867	-139		456,703	2.00
3.00	Subprovider - IRF	0	59,410	-115		144,989	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	21,792	45,286	0	3,217,038	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: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 1/25/2017 6:24 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 3901 HOSPITAL LANE	PO Box:			1.00
2.00	City: TERRE HAUTE	State: IN	Zip Code: 47802	County: VIGO	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	TERRE HAUTE REGIONAL HOSPITAL	150046	45460	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	TERRE HAUTE PSYCHIATRIC UNIT	15S046	45460	4	09/01/1991	N	P	O	4.00
5.00	Subprovider - IRF	TERRE HAUTE REHAB UNIT	15T046	45460	5	09/01/2006	N	P	O	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)	09/01/2015	08/31/2016	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	831	236	54	58	3,139	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.	60	35	0	0	244		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 1/25/2017 6:24 pm

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150046	Period: From 09/01/2015 To 08/31/2016	Worksheet S-2 Part I Date/Time Prepared: 1/25/2017 6:24 pm

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

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

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 1/25/2017 6:24 pm

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	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	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			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)	N	N	0	76.00

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	282,113	0	896,109	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00

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		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	44H070	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: HOSPITAL CORP. OF AMERICA	Contractor's Name: CAHABA	Contractor's Number: 10301	141.00
142.00	Street: ONE PARK PLAZA	PO Box:		142.00
143.00	City: NASHVILLE	State: TN	Zip Code: 37203	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	N	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)	9.99	169.00

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		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)	10/01/2014	12/29/2014	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: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 1/25/2017 6:24 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/01/2016	Y	12/01/2016	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

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		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2016	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DARRELL	CUNNINGHAM	41.00
42.00	Enter the employer/company name of the cost report preparer.	HCA		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-344-6147	DARRELL.CUNNINGHAM@HCAHEALTHCARE.COM	43.00

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		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 1/25/2017 6:24 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	142	51,972	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)		142	51,972	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	18	6,588	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		160	58,560	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	19	6,954		0	16.00
17.00	SUBPROVIDER - IRF	41.00	12	4,392		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC	99.00				0	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)		191				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

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	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)	10,985	1,179	19,282			1.00
2.00	HMO and other (see instructions)	1,721	3,073				2.00
3.00	HMO IPF Subprovider	88	0				3.00
4.00	HMO IRF Subprovider	17	244				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)	10,985	1,179	19,282			7.00
8.00	INTENSIVE CARE UNIT	1,767	0	3,365			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		0	563			13.00
14.00	Total (see instructions)	12,752	1,179	23,210	0.00	577.09	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,426	2,903	6,404	0.00	34.11	16.00
17.00	SUBPROVIDER - IRF	1,143	95	1,827	0.00	12.01	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	79			24.10
25.00	CMHC - CMHC	0	0	0	0.00	0.00	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	623.21	27.00
28.00	Observation Bed Days		928	2,589			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	66	91			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

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	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,828	329	5,481	1.00
2.00	HMO and other (see instructions)			302	971		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				14		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	2,828	329	5,481	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	179	0	953	16.00
17.00	SUBPROVIDER - IRF	0.00	0	84	5	134	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC	0.00					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

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	36,668,812	0	36,668,812	1,301,255.00	28.18	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,788,439	0	3,788,439	140,342.00	26.99	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,870,143	0	2,870,143	41,996.00	68.34	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		348,589	0	348,589	2,010.75	173.36	13.00
14.00	Home office salaries & wage-related costs		7,360,976	0	7,360,976	172,480.00	42.68	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,573,785	0	8,573,785			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		987,862	0	987,862			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	122,414	0	122,414	3,947.00	31.01	26.00
27.00	Administrative & General	5.00	3,622,159	-177,164	3,444,995	86,306.00	39.92	27.00
28.00	Administrative & General under contract (see inst.)		52,856	0	52,856	331.00	159.69	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	734,200	0	734,200	27,757.00	26.45	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	888,157	0	888,157	66,673.00	13.32	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	661,589	-216,304	445,285	35,897.00	12.40	34.00
35.00	Dietary under contract (see instructions)		226,909	0	226,909	2,536.00	89.48	35.00
36.00	Cafeteria	11.00	0	216,304	216,304	17,437.00	12.40	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	463,198	177,164	640,362	14,053.00	45.57	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 1/25/2017 6:24 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	60,894	0	60,894	2,974.00	20.48	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	1,478,973	0	1,478,973	51,163.00	28.91	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-3 Part III Date/Time Prepared: 1/25/2017 6:24 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		36,948,577	0	36,948,577	1,304,122.00	28.33	1.00
2.00	Excluded area salaries (see instructions)		3,788,439	0	3,788,439	140,342.00	26.99	2.00
3.00	Subtotal salaries (line 1 minus line 2)		33,160,138	0	33,160,138	1,163,780.00	28.49	3.00
4.00	Subtotal other wages & related costs (see inst.)		10,579,708	0	10,579,708	216,486.75	48.87	4.00
5.00	Subtotal wage-related costs (see inst.)		8,573,785	0	8,573,785	0.00	25.86	5.00
6.00	Total (sum of lines 3 thru 5)		52,313,631	0	52,313,631	1,380,266.75	37.90	6.00
7.00	Total overhead cost (see instructions)		8,311,349	0	8,311,349	309,074.00	26.89	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 150046	Period: From 09/01/2015 To 08/31/2016	Worksheet S-3 Part IV Date/Time Prepared: 1/25/2017 6:24 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,280,706	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	88,536	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	4,817,803	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	-601	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	33,849	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	416,560	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	105,304	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,134,776	17.00
18.00	Medicare Taxes - Employers Portion Only	495,438	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	-10,180	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	199,456	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,561,647	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 150046	Period: From 09/01/2015 To 08/31/2016	Worksheet S-3 Part V Date/Time Prepared: 1/25/2017 6:24 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	2,906,358	9,561,647	1.00
2.00	Hospital	2,870,143	8,573,785	2.00
3.00	Subprovider - IPF	33,289	453,066	3.00
4.00	Subprovider - IRF	2,926	210,024	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC	0	0	16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	324,772	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet S-10 | Date/Time Prepared: 1/25/2017 6:24 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.156249	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	16,300,910	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	143,361,773	6.00
7.00	Medicaid cost (line 1 times line 6)	22,400,134	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)	6,099,224	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	6,099,224	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,797,117	165,829	1,962,946	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	280,798	25,911	306,709	21.00
22.00	Partial payment by patients approved for charity care	3,377	2,210	5,587	22.00
23.00	Cost of charity care (line 21 minus line 22)	277,421	23,701	301,122	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	Y	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	3,911	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	5,027,433	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	525,596	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	4,501,837	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	703,408	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,004,530	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,103,754	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet A | Date/Time Prepared: 1/25/2017 6:24 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,481,788	2,481,788	199,729	2,681,517	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,580,501	2,580,501	921,412	3,501,913	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	122,414	7,217,347	7,339,761	114,720	7,454,481	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,622,159	8,971,012	12,593,171	-417,920	12,175,251	5.00
7.00	00700	OPERATION OF PLANT	734,200	2,640,637	3,374,837	-2,852	3,371,985	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	497,353	497,353	0	497,353	8.00
9.00	00900	HOUSEKEEPING	888,157	456,223	1,344,380	-16,101	1,328,279	9.00
10.00	01000	DIETARY	661,589	1,294,199	1,955,788	-642,138	1,313,650	10.00
11.00	01100	CAFETERIA	0	0	0	638,087	638,087	11.00
13.00	01300	NURSING ADMINISTRATION	463,198	84,985	548,183	166,706	714,889	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	60,894	1,024,121	1,085,015	-3,272	1,081,743	16.00
18.00	01850	INSERVICE EDUCATION	1,478,973	155,015	1,633,988	-4,341	1,629,647	18.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,997,385	2,754,708	8,752,093	34,721	8,786,814	30.00
31.00	03100	INTENSIVE CARE UNIT	1,930,817	692,473	2,623,290	-135,997	2,487,293	31.00
40.00	04000	SUBPROVIDER - IPF	1,737,503	1,144,669	2,882,172	-1,498	2,880,674	40.00
41.00	04100	SUBPROVIDER - IRF	805,441	110,260	915,701	-2,343	913,358	41.00
43.00	04300	NURSERY	177,346	60,163	237,509	-34	237,475	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,075,732	4,311,097	7,386,829	-33,220	7,353,609	50.00
51.00	05100	RECOVERY ROOM	574,355	95,070	669,425	-15	669,410	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	765,272	544,682	1,309,954	-8,174	1,301,780	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	966,032	1,574,913	2,540,945	-267,765	2,273,180	54.00
54.01	05401	ULTRASOUND	141,609	35,787	177,396	0	177,396	54.01
54.02	05402	MAMMOGRAPHY	161,823	110,300	272,123	-1,474	270,649	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	589,007	450,158	1,039,165	-35,663	1,003,502	55.00
56.00	05600	RADIOISOTOPE	221,699	752,979	974,678	-440	974,238	56.00
57.00	05700	CT SCAN	491,549	242,610	734,159	-37	734,122	57.00
58.00	05800	MRI	244,298	109,212	353,510	0	353,510	58.00
59.00	05900	CARDIAC CATHETERIZATION	517,462	207,607	725,069	-636	724,433	59.00
60.00	06000	LABORATORY	1,205,429	1,608,545	2,813,974	-115,616	2,698,358	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62,152	534,967	597,119	0	597,119	62.00
65.00	06500	RESPIRATORY THERAPY	1,026,185	656,820	1,683,005	-253,279	1,429,726	65.00
66.00	06600	PHYSICAL THERAPY	1,123,703	272,827	1,396,530	-1,586	1,394,944	66.00
69.00	06900	ELECTROCARDIOLOGY	483,814	311,364	795,178	-2,805	792,373	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	55,025	38,297	93,322	-15,804	77,518	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	334,641	5,613,065	5,947,706	-75,500	5,872,206	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,448,632	6,448,632	176,759	6,625,391	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,489,580	7,747,480	9,237,060	-13,112	9,223,948	73.00
74.00	07400	RENAL DIALYSIS	0	796,533	796,533	0	796,533	74.00
76.00	03020	LITHOTRIPSY	0	162,003	162,003	0	162,003	76.00
76.01	03330	ENDOSCOPY	331,914	408,378	740,292	-71,147	669,145	76.01
76.02	03950	PRISON CLINIC	128,644	29,429	158,073	-1,638	156,435	76.02
76.03	03951	WOUNDCARE	68,596	601,759	670,355	-846	669,509	76.03
76.04	03952	OPIC	438,578	136,463	575,041	-1,473	573,568	76.04
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	2,246,142	7,902,680	10,148,822	-123,821	10,025,001	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	0	99.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	35,423,317	73,869,111	109,292,428	1,587	109,294,015	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	30,184	23,675	53,859	0	53,859	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OCCUPATIONAL MEDICINE	984,185	217,599	1,201,784	-1,587	1,200,197	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
194.02	07952	SITTERS	231,126	19,931	251,057	0	251,057	194.02
200.00		TOTAL (SUM OF LINES 118-199)	36,668,812	74,130,316	110,799,128	0	110,799,128	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet A | Date/Time Prepared: 1/25/2017 6:24 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	129,363	2,810,880	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	13,241	3,515,154	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-244,012	7,210,469	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,432,084	16,607,335	5.00
7.00	00700	OPERATION OF PLANT	10,484	3,382,469	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	497,353	8.00
9.00	00900	HOUSEKEEPING	20,143	1,348,422	9.00
10.00	01000	DIETARY	-76	1,313,574	10.00
11.00	01100	CAFETERIA	-337,255	300,832	11.00
13.00	01300	NURSING ADMINISTRATION	-942	713,947	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	42,392	1,124,135	16.00
18.00	01850	INSERVICE EDUCATION	-1,469	1,628,178	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-706,816	8,079,998	30.00
31.00	03100	INTENSIVE CARE UNIT	-6,723	2,480,570	31.00
40.00	04000	SUBPROVIDER - IPF	-770,265	2,110,409	40.00
41.00	04100	SUBPROVIDER - IRF	-213	913,145	41.00
43.00	04300	NURSERY	219	237,694	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-3,419,491	3,934,118	50.00
51.00	05100	RECOVERY ROOM	0	669,410	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-30,077	1,271,703	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-659,231	1,613,949	54.00
54.01	05401	ULTRASOUND	0	177,396	54.01
54.02	05402	MAMMOGRAPHY	0	270,649	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	-1,304	1,002,198	55.00
56.00	05600	RADIOISOTOPE	0	974,238	56.00
57.00	05700	CT SCAN	-1,152	732,970	57.00
58.00	05800	MRI	-127	353,383	58.00
59.00	05900	CARDIAC CATHETERIZATION	-107	724,326	59.00
60.00	06000	LABORATORY	0	2,698,358	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	597,119	62.00
65.00	06500	RESPIRATORY THERAPY	-159,440	1,270,286	65.00
66.00	06600	PHYSICAL THERAPY	-38,036	1,356,908	66.00
69.00	06900	ELECTROCARDIOLOGY	-11,537	780,836	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	77,518	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-366	5,871,840	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,625,391	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,223,948	73.00
74.00	07400	RENAL DIALYSIS	0	796,533	74.00
76.00	03020	LITHOTRIPSY	0	162,003	76.00
76.01	03330	ENDOSCOPY	-77,100	592,045	76.01
76.02	03950	PRISON CLINIC	0	156,435	76.02
76.03	03951	WOUNDCARE	-5,697	663,812	76.03
76.04	03952	OPIC	-40,769	532,799	76.04
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	-6,767,605	3,257,396	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
99.00	09900	CMHC	0	0	99.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	-8,631,884	100,662,131	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-71	53,788	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	OCCUPATIONAL MEDICINE	-312,330	887,867	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.01
194.02	07952	SITTERS	-182	250,875	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-8,944,467	101,854,661	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - LEASES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	183,032	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	906,038	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
	0		0	1,089,070	
	B - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	31,310	1.00
	0		0	31,310	
	C - EXECUTIVE COMPENSATION				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	117,992	1.00
2.00	NURSING ADMINISTRATION	13.00	177,164	13,036	2.00
	0		177,164	131,028	
	D - CAFETERIA				
1.00	CAFETERIA	11.00	216,304	421,783	1.00
	0		216,304	421,783	
	E - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	147,513	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	36	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	0		0	147,549	
	F - DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	147	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
	0		0	147	
	G - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	228,447	1.00
2.00	INSERVICE EDUCATION	18.00	0	270	2.00
3.00		0.00	0	0	3.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
	0		0	228,717	
	H - ER BEDHOLD				
1.00	ADULTS & PEDIATRICS	30.00	73,170	39,159	1.00
2.00	INTENSIVE CARE UNIT	31.00	2,210	1,183	2.00
	0		75,380	40,342	
	I - LOST CHARGES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,191	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	0		0	1,191	
	J - EQUIPMENT PROPERTY TAX				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	14,613	1.00
	TOTALS		0	14,613	
	L - MISPOSTED LEASE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	761	1.00
	TOTALS		0	761	
500.00	Grand Total: Increases		468,848	2,106,511	500.00

RECLASSIFICATIONS | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet A-6 | Date/Time Prepared: 1/25/2017 6:24 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - LEASES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,272	10	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	77,657	10	2.00
3.00	OPERATION OF PLANT	7.00	0	2,852	0	3.00
4.00	HOUSEKEEPING	9.00	0	16,101	0	4.00
5.00	DIETARY	10.00	0	4,051	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	23,494	0	6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,272	0	7.00
8.00	INSERVICE EDUCATION	18.00	0	4,611	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	77,086	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	138,724	0	10.00
11.00	SUBPROVIDER - IPF	40.00	0	1,498	0	11.00
12.00	SUBPROVIDER - IRF	41.00	0	2,343	0	12.00
13.00	OPERATING ROOM	50.00	0	11,970	0	13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	0	6,886	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	260,494	0	15.00
16.00	MAMMOGRAPHY	54.02	0	1,474	0	16.00
17.00	RADIOLOGY-THERAPEUTIC	55.00	0	5,051	0	17.00
18.00	LABORATORY	60.00	0	114,199	0	18.00
19.00	RESPIRATORY THERAPY	65.00	0	194,952	0	19.00
20.00	PHYSICAL THERAPY	66.00	0	1,473	0	20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	15,804	0	21.00
22.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	44,601	0	22.00
23.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,473	0	23.00
24.00	ENDOSCOPY	76.01	0	70,326	0	24.00
25.00	PRISON CLINIC	76.02	0	1,473	0	25.00
26.00	WOUNDCARE	76.03	0	440	0	26.00
27.00	OPIC	76.04	0	1,473	0	27.00
28.00	OCCUPATIONAL MEDICINE	194.00	0	1,580	0	28.00
29.00	RADIOISOTOPE	56.00	0	440	0	29.00
	0		0	1,089,070		
	B - PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	31,310	12	1.00
	0		0	31,310		
	C - EXECUTIVE COMPENSATION					
1.00	ADMINISTRATIVE & GENERAL	5.00	177,164	131,028	0	1.00
2.00		0.00	0	0	0	2.00
	0		177,164	131,028		
	D - CAFETERIA					
1.00	DIETARY	10.00	216,304	421,783	0	1.00
	0		216,304	421,783		
	E - MEDICAL SUPPLIES					
1.00	ADULTS & PEDIATRICS	30.00	0	8	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	464	0	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	0	216	0	3.00
4.00	OPERATING ROOM	50.00	0	15,353	0	4.00
5.00	RECOVERY ROOM	51.00	0	7	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	7,271	0	6.00
7.00	CARDIAC CATHETERIZATION	59.00	0	604	0	7.00
8.00	LABORATORY	60.00	0	1,390	0	8.00
9.00	RESPIRATORY THERAPY	65.00	0	58,327	0	9.00
10.00	ELECTROCARDIOLOGY	69.00	0	2,797	0	10.00
11.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	51,688	0	11.00
12.00	PRISON CLINIC	76.02	0	165	0	12.00
13.00	WOUNDCARE	76.03	0	392	0	13.00
14.00	EMERGENCY	91.00	0	8,058	0	14.00
15.00	ENDOSCOPY	76.01	0	809	0	15.00
	0		0	147,549		
	F - DRUGS					
1.00	ADULTS & PEDIATRICS	30.00	0	9	0	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	35	0	2.00
3.00	EMERGENCY	91.00	0	41	0	3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	4	0	4.00
5.00	LABORATORY	60.00	0	25	0	5.00
6.00	ENDOSCOPY	76.01	0	12	0	6.00
7.00	WOUNDCARE	76.03	0	14	0	7.00
8.00	OCCUPATIONAL MEDICINE	194.00	0	7	0	8.00
	0		0	147		

RECLASSIFICATIONS | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet A-6 | Date/Time Prepared: 1/25/2017 6:24 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	G - IMPLANTABLE DEVICES						
1.00	ADULTS & PEDIATRICS	30.00	0	40	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	17	0		2.00
3.00	NURSERY	43.00	0	34	0		3.00
4.00	OPERATING ROOM	50.00	0	5,725	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,068	0		5.00
6.00	RECOVERY ROOM	51.00	0	8	0		6.00
7.00	RADIOLOGY-THERAPEUTIC	55.00	0	30,612	0		7.00
8.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	179,568	0		8.00
9.00	ELECTROCARDIOLOGY	69.00	0	8	0		9.00
10.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,522	0		10.00
11.00	LABORATORY	60.00	0	2	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	113	0		12.00
	0		0	228,717			
	H - ER BEDHOLD						
1.00	EMERGENCY	91.00	75,380	40,342	0		1.00
2.00		0.00	0	0	0		2.00
	0		75,380	40,342			
	I - LOST CHARGES						
1.00	ADULTS & PEDIATRICS	30.00	0	465	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	185	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	32	0		3.00
4.00	CT SCAN	57.00	0	37	0		4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	300	0		5.00
6.00	OPERATING ROOM	50.00	0	172	0		6.00
	0		0	1,191			
	J - EQUIPMENT PROPERTY TAX						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	14,613	13		1.00
	TOTALS		0	14,613			
	L - MISPOSTED LEASE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	761	10		1.00
	TOTALS		0	761			
500.00	Grand Total: Decreases		468,848	2,106,511			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet A-7 Part I Date/Time Prepared: 1/25/2017 6:24 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,262,718	0	0	0	0	1.00
2.00	Land Improvements	3,158,371	0	0	0	0	2.00
3.00	Buildings and Fixtures	38,638,215	0	0	0	0	3.00
4.00	Building Improvements	7,429,901	335,068	0	335,068	0	4.00
5.00	Fixed Equipment	26,731,459	327,945	0	327,945	0	5.00
6.00	Movable Equipment	54,005,249	4,125,653	0	4,125,653	14,699,400	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	131,225,913	4,788,666	0	4,788,666	14,699,400	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	131,225,913	4,788,666	0	4,788,666	14,699,400	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,262,718	0	1.00
2.00	Land Improvements	3,158,371	0	2.00
3.00	Buildings and Fixtures	38,638,215	0	3.00
4.00	Building Improvements	7,764,969	0	4.00
5.00	Fixed Equipment	27,059,404	0	5.00
6.00	Movable Equipment	43,431,502	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	121,315,179	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	121,315,179	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet A-7 Part II | Date/Time Prepared: 1/25/2017 6:24 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,363,298	0	0	0	118,490	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,456,294	106,667	17,540	0	0	2.00
3.00	Total (sum of lines 1-2)	4,819,592	106,667	17,540	0	118,490	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	2,481,788	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,580,501	2.00
3.00	Total (sum of lines 1-2)	0	5,062,289	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 1/25/2017 6:24 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	77,883,667	0	77,883,667	0.641994	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	43,431,502	0	43,431,502	0.358006	0	2.00
3.00	Total (sum of lines 1-2)	121,315,169	0	121,315,169	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,492,661	183,032	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,469,535	1,013,466	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,962,196	1,196,498	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	31,310	103,877	0	2,810,880	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	17,540	0	14,613	0	3,515,154	2.00
3.00	Total (sum of lines 1-2)	17,540	31,310	118,490	0	6,326,034	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet A-8 | Date/Time Prepared: 1/25/2017 6:24 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		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	-9,285,578			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	4,784,802			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	X-RAY COPY	B	-345	RADIOLOGY-DIAGNOSTIC	54.00	0	33.00
33.01	CAFETERIA	B	-316,991	CAFETERIA	11.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet A-8 | Date/Time Prepared: 1/25/2017 6:24 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	VENDING	B	-20,264	CAFETERIA	11.00	0	33.02
33.03	ED OTHER	B	-299	INSERVICE EDUCATION	18.00	0	33.03
33.04	MEDICAL RECORDS	B	-1,346	MEDICAL RECORDS & LIBRARY	16.00	0	33.04
33.05	SCRAP METAL	B	-312	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	COMP REHAB	B	-16	ELECTROCARDIOLOGY	69.00	0	33.06
33.07	INTEREST INCOME	B	-12,805	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	HOSPICE	B	-58,879	ADULTS & PEDIATRICS	30.00	0	33.08
33.09	UNCLAIMED PROPERTY	B	-3,639	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	WORKER'S COMP. PAID CLAIMS	A	5,157	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	WORKER'S COMP INSURANCE	A	-54,027	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	PATIENT ACCOUNT INTEREST	A	-2,375	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	PATIENT TELEPHONES	A	-9,876	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	PATIENT TELEPHONES	A	-48,196	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	PATIENT TV'S	A	22,635	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	PATIENT TV'S	A	-67,528	OPERATION OF PLANT	7.00	0	33.16
33.17	CONSULTING 900-317	A	-25,841	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	ADMIN. TRAVEL 900-750	A	-7,150	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	ADMIN. MEALS 900-764	A	-7,173	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	MISC. XXX870	A	-6,017	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	NONPATIENT GIFTS	A	-207	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.21
33.22	NONPATIENT GIFTS	A	-37,113	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	NONPATIENT GIFTS	A	-444	INSERVICE EDUCATION	18.00	0	33.23
33.24	NONPATIENT GIFTS	A	-63	EMERGENCY	91.00	0	33.24
33.25	PATIENT GIFTS	A	-300	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	SPOUSE TRAVEL	A	-98	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	ALCOHOL	A	-5,132	ADMINISTRATIVE & GENERAL	5.00	0	33.27
33.28	ALCOHOL	A	-29	INSERVICE EDUCATION	18.00	0	33.28
33.29	ALCOHOL	A	-3	ADULTS & PEDIATRICS	30.00	0	33.29
33.30	ALCOHOL	A	-9	INTENSIVE CARE UNIT	31.00	0	33.30
33.31	ALCOHOL	A	-22	EMERGENCY	91.00	0	33.31
33.32	COUNTRY CLUB DUES	A	-3,270	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	PHYSICIAN RECRUITMENT	A	-43,519	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	PHYSICIAN RECRUITMENT	A	-76	DIETARY	10.00	0	33.34
33.35	NONALLOWABLES 900805	A	-23,595	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36	CONTRIBUTIONS	A	-29,025	ADMINISTRATIVE & GENERAL	5.00	0	33.36
33.37	PENALTIES	A	-814	OPERATION OF PLANT	7.00	0	33.37
33.38	MED STAFF NONALLOWABLES 843971	A	-48,862	ADMINISTRATIVE & GENERAL	5.00	0	33.38
33.39	POB DEPT. 858	A	294	ADMINISTRATIVE & GENERAL	5.00	0	33.39
33.40	MARKETING DEPT. 919718	A	-6,452	ADMINISTRATIVE & GENERAL	5.00	0	33.40
33.41	PUBLIC RELATIONS DEPT. 920	A	-43,062	ADMINISTRATIVE & GENERAL	5.00	0	33.41
33.42	SALES DEPT. 965	A	-452	ADMINISTRATIVE & GENERAL	5.00	0	33.42
33.43	LEGAL FEES	A	-53,260	ADMINISTRATIVE & GENERAL	5.00	0	33.43
33.44	CLINICAL RESEARCH	A	-1,222	RADIOLOGY-THERAPEUTIC	55.00	0	33.44
33.45	CLINICAL RESEARCH	A	-208	OPIC	76.04	0	33.45
33.46	CLINICAL RESEARCH	A	-245	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.46
33.47	CRNA	A	-2,956,800	OPERATING ROOM	50.00	0	33.47
33.48	NURSE PRACTITIONER	A	-283,530	OCCUPATIONAL MEDICINE	194.00	0	33.48
33.49	NURSE PRACTITIONER	A	-697	INSERVICE EDUCATION	18.00	0	33.49
33.50	LOBBYING DUES	A	-9,737	ADMINISTRATIVE & GENERAL	5.00	0	33.50
33.51	MOB ACCOUNTING	A	-1,083	ADMINISTRATIVE & GENERAL	5.00	0	33.51
33.52	MOB ACCOUNTING	A	-287	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.52
33.53	USEFUL LIFE ADJUSTMENT	A	-44,483	CAP REL COSTS-BLDG & FIXT	1.00	9	33.53
33.54	PHYSICIAN RECORDS STORAGE	A	-13	OPERATION OF PLANT	7.00	0	33.54
33.55	SOFTWARE AMORTIZATION	A	12,952	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.55
33.56	ADVERTISING	A	-62,033	ADMINISTRATIVE & GENERAL	5.00	0	33.56
33.57	ADVERTISING	A	-82	RADIOLOGY-THERAPEUTIC	55.00	0	33.57
33.58	ADVERTISING	A	-121	OPIC	76.04	0	33.58
33.59	ADVERTISING	A	-185,231	EMERGENCY	91.00	0	33.59
33.60	ADVERTISING	A	-71	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	33.60
33.61			0		0.00	0	33.61
33.62			0		0.00	0	33.62
33.63			0		0.00	0	33.63
33.64			0		0.00	0	33.64
33.65			0		0.00	0	33.65
33.66			0		0.00	0	33.66
33.67			0		0.00	0	33.67
33.68			0		0.00	0	33.68
33.69			0		0.00	0	33.69

ADJUSTMENTS TO EXPENSES | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet A-8 | Date/Time Prepared: 1/25/2017 6:24 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.70			0		0.00	0	33.70
33.71			0		0.00	0	33.71
33.72			0		0.00	0	33.72
33.73			0		0.00	0	33.73
33.74			0		0.00	0	33.74
33.75			0		0.00	0	33.75
33.76			0		0.00	0	33.76
33.77			0		0.00	0	33.77
33.78			0		0.00	0	33.78
33.79			0		0.00	0	33.79
33.80			0		0.00	0	33.80
33.81			0		0.00	0	33.81
33.82			0		0.00	0	33.82
33.83			0		0.00	0	33.83
33.84			0		0.00	0	33.84
33.85			0		0.00	0	33.85
33.86			0		0.00	0	33.86
33.87			0		0.00	0	33.87
33.88			0		0.00	0	33.88
33.89			0		0.00	0	33.89
33.90			0		0.00	0	33.90
33.91			0		0.00	0	33.91
33.92			0		0.00	0	33.92
33.93			0		0.00	0	33.93
33.94			0		0.00	0	33.94
33.95			0		0.00	0	33.95
33.96			0		0.00	0	33.96
33.97			0		0.00	0	33.97
33.98			0		0.00	0	33.98
33.99			0		0.00	0	33.99
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,944,467				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: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 1/25/2017 6:24 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HPG	94,049	180,961	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	IT&S	1,567,982	1,657,186	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE COST	2,172,409	7,345,733	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE DIRECT COMP.	348,108	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	SSC	2,501,602	2,501,602	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	SUPPLY CHAIN	1,253,182	1,253,182	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	PARALLON WORKFORCE SOLUTIONS	-2,909	-2,909	4.03
4.04	13.00	NURSING ADMINISTRATION	PARALLON WORKFORCE SOLUTIONS	12,018	12,960	4.04
4.05	16.00	MEDICAL RECORDS & LIBRARY	PARALLON WORKFORCE SOLUTIONS	2,744	2,959	4.05
4.06	30.00	ADULTS & PEDIATRICS	PARALLON WORKFORCE SOLUTIONS	912,413	983,946	4.06
4.07	31.00	INTENSIVE CARE UNIT	PARALLON WORKFORCE SOLUTIONS	85,642	92,356	4.07
4.08	40.00	SUBPROVIDER - IPF	PARALLON WORKFORCE SOLUTIONS	30,869	33,289	4.08
4.09	41.00	SUBPROVIDER - IRF	PARALLON WORKFORCE SOLUTIONS	2,713	2,926	4.09
4.10	43.00	NURSERY	PARALLON WORKFORCE SOLUTIONS	-2,789	-3,008	4.10
4.11	50.00	OPERATING ROOM	PARALLON WORKFORCE SOLUTIONS	475,485	512,763	4.11
4.12	52.00	DELIVERY ROOM & LABOR ROOM	PARALLON WORKFORCE SOLUTIONS	383,642	413,719	4.12
4.13	57.00	CT SCAN	PARALLON WORKFORCE SOLUTIONS	14,693	15,845	4.13
4.14	58.00	MRI	PARALLON WORKFORCE SOLUTIONS	1,619	1,746	4.14
4.15	59.00	CARDIAC CATHETERIZATION	PARALLON WORKFORCE SOLUTIONS	1,360	1,467	4.15
4.16	65.00	RESPIRATORY THERAPY	PARALLON WORKFORCE SOLUTIONS	3,066	3,306	4.16
4.17	66.00	PHYSICAL THERAPY	PARALLON WORKFORCE SOLUTIONS	72,863	78,575	4.17
4.18	71.00	MEDICAL SUPPLIES CHARGED TO	PARALLON WORKFORCE SOLUTIONS	4,669	5,035	4.18
4.19	91.00	EMERGENCY	PARALLON WORKFORCE SOLUTIONS	521,717	562,619	4.19
4.20	194.02	SITTERS	PARALLON WORKFORCE SOLUTIONS	2,322	2,504	4.20
4.21	5.00	ADMINISTRATIVE & GENERAL	PARALLON MARK-UP	0	729,187	4.21
4.22	5.00	ADMINISTRATIVE & GENERAL	PARALLON PAYROLL	34,530	34,530	4.22
4.23	5.00	ADMINISTRATIVE & GENERAL	CAPITAL DIVISION IT&S	1,345,866	1,345,291	4.23
4.24	16.00	MEDICAL RECORDS & LIBRARY	HIM	996,761	949,845	4.24
4.25	16.00	MEDICAL RECORDS & LIBRARY	ICD-10 FEES	31,970	36,256	4.25
4.26	5.00	ADMINISTRATIVE & GENERAL	REVENUE INTEGRITY	136,968	136,968	4.26
4.27	5.00	ADMINISTRATIVE & GENERAL	CREDENTIALING	70,730	70,730	4.27
4.28	40.00	SUBPROVIDER - IPF	BEHAVIORAL HEALTH	132,035	171,471	4.28
4.29	5.00	ADMINISTRATIVE & GENERAL	IT&S PARALLON	302,486	302,486	4.29
4.30	16.00	MEDICAL RECORDS & LIBRARY	PREBILL DENIAL	25,483	24,160	4.30
4.31	4.00	EMPLOYEE BENEFITS DEPARTMENT	HCA HR SERVICES	280,831	397,951	4.31
4.32	5.00	ADMINISTRATIVE & GENERAL	CALL CENTER	0	69,917	4.32
4.33	5.00	ADMINISTRATIVE & GENERAL	PHYSICIAN RECRUITING	0	80,770	4.33
4.34	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	64,253	744,485	4.34
4.35	5.00	ADMINISTRATIVE & GENERAL	GENERAL LIABILITY INSURANCE	0	7,133	4.35
4.36	5.00	ADMINISTRATIVE & GENERAL	PHYSICIAN SALES	0	168,822	4.36
4.37	5.00	ADMINISTRATIVE & GENERAL	MARKETING ALLOCATIONS	0	129,935	4.37
4.38	5.00	ADMINISTRATIVE & GENERAL	RICHMOND FSC	160,234	170,220	4.38
4.39	4.00	EMPLOYEE BENEFITS DEPARTMENT	RESTORATION PLAN EXP.	0	180	4.39
4.40	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INS_POOLING ADJ.	0	67,227	4.40
4.41	5.00	ADMINISTRATIVE & GENERAL	INTERCOMPANY INTEREST	0	-11,153,140	4.41
4.42	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE INTEREST	570,231	0	4.42
4.43	1.00	CAP REL COSTS-BLDG & FIXT	POB SPACE	96,825	0	4.43
4.44	2.00	CAP REL COSTS-MVBLE EQUIP	POB SPACE	289	0	4.44
4.45	5.00	ADMINISTRATIVE & GENERAL	POB SPACE	41,546	0	4.45
4.46	7.00	OPERATION OF PLANT	POB SPACE	53,865	0	4.46
4.47	9.00	HOUSEKEEPING	POB SPACE	16,720	0	4.47
4.48	1.00	CAP REL COSTS-BLDG & FIXT	PAVILLION SPACE	77,021	0	4.48
4.49	5.00	ADMINISTRATIVE & GENERAL	PAVILLION SPACE	1,478	0	4.49
4.50	7.00	OPERATION OF PLANT	PAVILLION SPACE	24,974	0	4.50
4.51	9.00	HOUSEKEEPING	PAVILLION SPACE	3,423	0	4.51
4.52	0.00			0	0	4.52
4.53	0.00			0	0	4.53
4.54	0.00			0	0	4.54
4.55	0.00			0	0	4.55
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			14,927,988	10,143,186	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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet A-8-1 Date/Time Prepared: 1/25/2017 6:24 pm

	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.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		100.00	PARALLON	100.00	6.00
7.00	B		54.40	HPG	54.40	7.00
8.00	B		100.00	HCI	100.00	8.00
9.00	B		100.00	CAPITAL DIVISIO	100.00	9.00
10.00	B		100.00	WORKFORCE MGT.	100.00	10.00
10.01	B		100.00	HCA	100.00	10.01
10.02	B		100.00	POB	100.00	10.02
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: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 1/25/2017 6:24 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	-86,912	0	1.00
2.00	-89,204	0	2.00
3.00	-5,173,324	0	3.00
4.00	348,108	0	4.00
4.01	0	0	4.01
4.02	0	0	4.02
4.03	0	0	4.03
4.04	-942	0	4.04
4.05	-215	0	4.05
4.06	-71,533	0	4.06
4.07	-6,714	0	4.07
4.08	-2,420	0	4.08
4.09	-213	0	4.09
4.10	219	0	4.10
4.11	-37,278	0	4.11
4.12	-30,077	0	4.12
4.13	-1,152	0	4.13
4.14	-127	0	4.14
4.15	-107	0	4.15
4.16	-240	0	4.16
4.17	-5,712	0	4.17
4.18	-366	0	4.18
4.19	-40,902	0	4.19
4.20	-182	0	4.20
4.21	-729,187	0	4.21
4.22	0	0	4.22
4.23	575	0	4.23
4.24	46,916	0	4.24
4.25	-4,286	0	4.25
4.26	0	0	4.26
4.27	0	0	4.27
4.28	-39,436	0	4.28
4.29	0	0	4.29
4.30	1,323	0	4.30
4.31	-117,120	0	4.31
4.32	-69,917	0	4.32
4.33	-80,770	9	4.33
4.34	-680,232	0	4.34
4.35	-7,133	0	4.35
4.36	-168,822	0	4.36
4.37	-129,935	0	4.37
4.38	-9,986	0	4.38
4.39	-180	0	4.39
4.40	-67,227	0	4.40
4.41	11,153,140	0	4.41
4.42	570,231	0	4.42
4.43	96,825	9	4.43
4.44	289	9	4.44
4.45	41,546	0	4.45
4.46	53,865	0	4.46
4.47	16,720	0	4.47
4.48	77,021	9	4.48
4.49	1,478	0	4.49
4.50	24,974	0	4.50
4.51	3,423	0	4.51
4.52	0	0	4.52
4.53	0	0	4.53
4.54	0	0	4.54
4.55	0	0	4.55
5.00	4,784,802		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		

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 150046	Period: From 09/01/2015 To 08/31/2016	Worksheet A-8-1 Date/Time Prepared: 1/25/2017 6:24 pm

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

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

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

6.00	MANAGEMENT		6.00
7.00	PURCHASING		7.00
8.00	INSURANCE		8.00
9.00	MANAGEMENT		9.00
10.00	STAFFING		10.00
10.01	HOSPITAL MGT.		10.01
10.02	PROFESSIONAL BU		10.02
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: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 1/25/2017 6:24 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	604,262	553,024	51,238	211,500	274	1.00
2.00	40.00	SUBPROVIDER - IPF	728,409	728,409	0	181,300	0	2.00
3.00	50.00	OPERATING ROOM	446,381	421,955	24,426	246,400	177	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	658,886	658,886	0	271,900	0	4.00
5.00	65.00	RESPIRATORY THERAPY	159,200	159,200	0	211,500	0	5.00
6.00	66.00	PHYSICAL THERAPY	73,200	12,900	60,300	211,500	402	6.00
7.00	69.00	ELECTROCARDIOLOGY	35,925	0	35,925	211,500	240	7.00
8.00	76.01	ENDOSCOPY	77,100	77,100	0	246,400	0	8.00
9.00	76.03	WOUNDCARE	24,000	-3,000	27,000	211,500	180	9.00
10.00	76.04	OPIC	88,638	0	88,638	211,500	474	10.00
11.00	91.00	EMERGENCY	6,568,231	6,507,169	61,062	211,500	264	11.00
12.00	194.00	OCCUPATIONAL MEDICINE	28,800	28,800	0	211,500	0	12.00
200.00			9,493,032	9,144,443	348,589		2,011	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	27,861	1,393	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	20,968	1,048	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	66.00	PHYSICAL THERAPY	40,876	2,044	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	24,404	1,220	0	0	0	7.00
8.00	76.01	ENDOSCOPY	0	0	0	0	0	8.00
9.00	76.03	WOUNDCARE	18,303	915	0	0	0	9.00
10.00	76.04	OPIC	48,198	2,410	0	0	0	10.00
11.00	91.00	EMERGENCY	26,844	1,342	0	0	0	11.00
12.00	194.00	OCCUPATIONAL MEDICINE	0	0	0	0	0	12.00
200.00			207,454	10,372	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	27,861	23,377	576,401		1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	728,409		2.00
3.00	50.00	OPERATING ROOM	0	20,968	3,458	425,413		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	658,886		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	159,200		5.00
6.00	66.00	PHYSICAL THERAPY	0	40,876	19,424	32,324		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	24,404	11,521	11,521		7.00
8.00	76.01	ENDOSCOPY	0	0	0	77,100		8.00
9.00	76.03	WOUNDCARE	0	18,303	8,697	5,697		9.00
10.00	76.04	OPIC	0	48,198	40,440	40,440		10.00
11.00	91.00	EMERGENCY	0	26,844	34,218	6,541,387		11.00
12.00	194.00	OCCUPATIONAL MEDICINE	0	0	0	28,800		12.00
200.00			0	207,454	141,135	9,285,578		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet B Part I Date/Time Prepared: 1/25/2017 6:24 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,810,880	2,810,880				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,515,154		3,515,154			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,210,469	29,032	36,607	7,276,108		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,607,335	187,261	236,122	685,871	17,716,589	5.00
7.00	00700	OPERATION OF PLANT	3,382,469	647,015	815,834	146,173	4,991,491	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	497,353	27,414	34,567	0	559,334	8.00
9.00	00900	HOUSEKEEPING	1,348,422	9,863	12,437	176,825	1,547,547	9.00
10.00	01000	DIETARY	1,313,574	44,779	56,463	88,653	1,503,469	10.00
11.00	01100	CAFETERIA	300,832	28,560	36,012	43,064	408,468	11.00
13.00	01300	NURSING ADMINISTRATION	713,947	7,664	9,664	127,491	858,766	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,124,135	44,137	55,653	12,124	1,236,049	16.00
18.00	01850	INSERVICE EDUCATION	1,628,178	42,070	53,046	294,452	2,017,746	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,079,998	483,575	609,750	1,208,615	10,381,938	30.00
31.00	03100	INTENSIVE CARE UNIT	2,480,570	82,289	103,760	384,850	3,051,469	31.00
40.00	04000	SUBPROVIDER - IPF	2,110,409	74,291	93,675	345,923	2,624,298	40.00
41.00	04100	SUBPROVIDER - IRF	913,145	88,320	111,364	160,357	1,273,186	41.00
43.00	04300	NURSERY	237,694	8,083	10,191	35,308	291,276	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,934,118	195,274	246,225	612,354	4,987,971	50.00
51.00	05100	RECOVERY ROOM	669,410	12,194	15,375	114,349	811,328	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,271,703	55,602	70,110	152,360	1,549,775	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,613,949	101,171	127,569	192,329	2,035,018	54.00
54.01	05401	ULTRASOUND	177,396	3,143	3,963	28,193	212,695	54.01
54.02	05402	MAMMOGRAPHY	270,649	11,574	14,594	32,218	329,035	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,002,198	47,822	60,299	117,267	1,227,586	55.00
56.00	05600	RADIOISOTOPE	974,238	5,745	7,243	44,138	1,031,364	56.00
57.00	05700	CT SCAN	732,970	12,403	15,639	97,863	858,875	57.00
58.00	05800	MRI	353,383	8,052	10,152	48,638	420,225	58.00
59.00	05900	CARDIAC CATHETERIZATION	724,326	17,752	22,384	103,023	867,485	59.00
60.00	06000	LABORATORY	2,698,358	41,435	52,246	239,991	3,032,030	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	597,119	2,477	3,124	12,374	615,094	62.00
65.00	06500	RESPIRATORY THERAPY	1,270,286	12,689	16,000	204,305	1,503,280	65.00
66.00	06600	PHYSICAL THERAPY	1,356,908	105,174	132,616	223,720	1,818,418	66.00
69.00	06900	ELECTROCARDIOLOGY	780,836	16,970	21,398	96,323	915,527	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	77,518	8,439	10,641	10,955	107,553	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,871,840	65,737	82,889	66,624	6,087,090	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,625,391	0	0	0	6,625,391	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,223,948	20,787	26,211	296,563	9,567,509	73.00
74.00	07400	RENAL DIALYSIS	796,533	3,654	4,608	0	804,795	74.00
76.00	03020	LITHOTRIPSY	162,003	0	0	0	162,003	76.00
76.01	03330	ENDOSCOPY	592,045	14,903	18,792	66,081	691,821	76.01
76.02	03950	PRISON CLINIC	156,435	58,064	73,214	25,612	313,325	76.02
76.03	03951	WOUNDCARE	663,812	13,378	16,869	13,657	707,716	76.03
76.04	03952	OPIC	532,799	29,613	37,339	87,317	687,068	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,257,396	79,595	100,362	432,181	3,869,534	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	100,662,131	2,748,000	3,465,007	7,028,141	100,301,137	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	53,788	4,699	5,925	6,009	70,421	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OCCUPATIONAL MEDICINE	887,867	35,071	44,222	195,943	1,163,103	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	23,110	0	0	23,110	194.01
194.02	07952	SITTERS	250,875	0	0	46,015	296,890	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	101,854,661	2,810,880	3,515,154	7,276,108	101,854,661	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet B Part I Date/Time Prepared: 1/25/2017 6:24 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,716,589					5.00
7.00	00700	OPERATION OF PLANT	1,051,038	6,042,529				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	117,777	85,055	762,166			8.00
9.00	00900	HOUSEKEEPING	325,861	30,602	55,039	1,959,049		9.00
10.00	01000	DIETARY	316,579	138,932	0	45,922	2,004,902	10.00
11.00	01100	CAFETERIA	86,009	88,610	0	29,289	0	11.00
13.00	01300	NURSING ADMINISTRATION	180,827	23,780	0	7,860	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	260,270	136,938	0	45,263	0	16.00
18.00	01850	INSERVICE EDUCATION	424,869	130,525	0	43,143	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,186,055	1,500,338	294,095	495,920	948,068	30.00
31.00	03100	INTENSIVE CARE UNIT	642,536	255,309	62,421	84,389	56,515	31.00
40.00	04000	SUBPROVIDER - IPF	552,588	230,496	36,319	76,187	292,185	40.00
41.00	04100	SUBPROVIDER - IRF	268,090	274,021	8,504	90,574	121,084	41.00
43.00	04300	NURSERY	61,333	25,077	0	8,289	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,050,297	605,857	62,421	200,258	0	50.00
51.00	05100	RECOVERY ROOM	170,838	37,832	0	12,505	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	326,330	172,512	11,811	57,022	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	428,506	313,894	37,028	103,753	0	54.00
54.01	05401	ULTRASOUND	44,786	9,752	0	3,223	0	54.01
54.02	05402	MAMMOGRAPHY	69,284	35,910	0	11,870	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	258,488	148,372	0	49,042	0	55.00
56.00	05600	RADIOISOTOPE	217,170	17,823	0	5,891	0	56.00
57.00	05700	CT SCAN	180,850	38,480	0	12,719	0	57.00
58.00	05800	MRI	88,485	24,981	0	8,257	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	182,663	55,078	0	18,205	0	59.00
60.00	06000	LABORATORY	638,442	128,555	0	42,492	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	129,518	7,686	0	2,541	0	62.00
65.00	06500	RESPIRATORY THERAPY	316,540	39,369	0	13,013	0	65.00
66.00	06600	PHYSICAL THERAPY	382,897	326,312	13,701	107,858	0	66.00
69.00	06900	ELECTROCARDIOLOGY	192,779	52,652	5,315	17,403	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	22,647	26,182	0	8,654	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,281,734	203,954	75,295	67,414	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,395,082	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,014,592	64,494	0	21,318	0	73.00
74.00	07400	RENAL DIALYSIS	169,462	11,337	0	3,747	0	74.00
76.00	03020	LITHOTRIPSY	34,112	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	145,674	46,239	0	15,284	0	76.01
76.02	03950	PRISON CLINIC	65,976	180,150	0	59,546	0	76.02
76.03	03951	WOUNDCARE	149,021	41,507	9,154	13,719	0	76.03
76.04	03952	OPIC	144,673	91,877	6,850	30,369	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	814,792	246,950	84,213	81,626	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,389,470	5,847,438	762,166	1,894,565	1,417,852	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,828	14,580	0	4,819	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OCCUPATIONAL MEDICINE	244,910	108,811	0	35,966	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	4,866	71,700	0	23,699	587,050	194.01
194.02	07952	SITTERS	62,515	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	17,716,589	6,042,529	762,166	1,959,049	2,004,902	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet B Part I Date/Time Prepared: 1/25/2017 6:24 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	
			11.00	13.00	16.00	18.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	612,376					11.00
13.00	01300	NURSING ADMINISTRATION	8,094	1,079,327				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,713	0	1,680,233			16.00
18.00	01850	INSERVICE EDUCATION	29,468	81,313	0	2,727,064		18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	133,128	390,327	61,742	739,803	17,131,414	30.00
31.00	03100	INTENSIVE CARE UNIT	34,256	98,183	23,242	194,764	4,503,084	31.00
40.00	04000	SUBPROVIDER - IPF	41,021	114,521	59,570	360,369	4,387,554	40.00
41.00	04100	SUBPROVIDER - IRF	14,443	40,001	5,793	41,869	2,137,565	41.00
43.00	04300	NURSERY	3,099	8,927	2,146	16,075	416,222	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	61,985	0	223,213	87,849	7,279,851	50.00
51.00	05100	RECOVERY ROOM	8,301	0	31,237	36,261	1,108,302	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,909	41,140	8,499	53,083	2,235,081	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,098	0	38,219	29,532	3,011,048	54.00
54.01	05401	ULTRASOUND	2,995	0	9,720	14,205	297,376	54.01
54.02	05402	MAMMOGRAPHY	3,491	0	6,401	29,158	485,149	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	9,696	26,754	42,036	44,859	1,806,833	55.00
56.00	05600	RADIOISOTOPE	3,249	0	32,680	4,860	1,313,037	56.00
57.00	05700	CT SCAN	10,265	0	125,369	33,271	1,259,829	57.00
58.00	05800	MRI	4,213	0	34,870	4,860	585,891	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,503	17,943	57,675	23,551	1,229,103	59.00
60.00	06000	LABORATORY	31,477	0	165,709	37,756	4,076,461	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,510	0	17,473	1,495	775,317	62.00
65.00	06500	RESPIRATORY THERAPY	19,569	53,999	49,050	62,055	2,056,875	65.00
66.00	06600	PHYSICAL THERAPY	15,958	0	18,900	109,905	2,793,949	66.00
69.00	06900	ELECTROCARDIOLOGY	10,832	29,890	40,563	25,794	1,290,755	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,084	2,991	4,111	1,869	175,091	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,698	0	104,720	0	7,829,905	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	49,678	0	8,070,151	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,131	0	266,071	0	11,958,115	73.00
74.00	07400	RENAL DIALYSIS	0	0	14,656	0	1,003,997	74.00
76.00	03020	LITHOTRIPSY	0	0	3,404	0	199,519	76.00
76.01	03330	ENDOSCOPY	4,643	0	20,144	31,028	954,833	76.01
76.02	03950	PRISON CLINIC	2,412	0	928	0	622,337	76.02
76.03	03951	WOUNDCARE	1,197	6,654	8,830	8,972	946,770	76.03
76.04	03952	OPIC	8,573	23,657	16,330	0	1,009,397	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	39,999	120,783	137,254	708,027	6,103,178	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	587,010	1,057,083	1,680,233	2,701,270	99,053,989	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	965	0	0	0	105,613	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OCCUPATIONAL MEDICINE	16,693	0	0	21,308	1,590,791	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	710,425	194.01
194.02	07952	SITTERS	7,708	22,244	0	4,486	393,843	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	612,376	1,079,327	1,680,233	2,727,064	101,854,661	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet B Part I Date/Time Prepared: 1/25/2017 6:24 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
18.00	01850	INSERVICE EDUCATION			18.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	17,131,414	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,503,084	31.00
40.00	04000	SUBPROVIDER - IPF	0	4,387,554	40.00
41.00	04100	SUBPROVIDER - IRF	0	2,137,565	41.00
43.00	04300	NURSERY	0	416,222	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	7,279,851	50.00
51.00	05100	RECOVERY ROOM	0	1,108,302	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,235,081	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,011,048	54.00
54.01	05401	ULTRASOUND	0	297,376	54.01
54.02	05402	MAMMOGRAPHY	0	485,149	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,806,833	55.00
56.00	05600	RADIOISOTOPE	0	1,313,037	56.00
57.00	05700	CT SCAN	0	1,259,829	57.00
58.00	05800	MRI	0	585,891	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,229,103	59.00
60.00	06000	LABORATORY	0	4,076,461	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	775,317	62.00
65.00	06500	RESPIRATORY THERAPY	0	2,056,875	65.00
66.00	06600	PHYSICAL THERAPY	0	2,793,949	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,290,755	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	175,091	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,829,905	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,070,151	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,958,115	73.00
74.00	07400	RENAL DIALYSIS	0	1,003,997	74.00
76.00	03020	LITHOTRIPSY	0	199,519	76.00
76.01	03330	ENDOSCOPY	0	954,833	76.01
76.02	03950	PRISON CLINIC	0	622,337	76.02
76.03	03951	WOUNDCARE	0	946,770	76.03
76.04	03952	OPIC	0	1,009,397	76.04
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	6,103,178	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.00	09900	CMHC	0	0	99.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	99,053,989	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	105,613	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	OCCUPATIONAL MEDICINE	0	1,590,791	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	710,425	194.01
194.02	07952	SITTERS	0	393,843	194.02
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	101,854,661	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet B Part II | Date/Time Prepared: 1/25/2017 6:24 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	29,032	36,607	65,639	65,639	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,012,070	187,261	236,122	2,435,453	6,187	5.00
7.00	00700	OPERATION OF PLANT	0	647,015	815,834	1,462,849	1,319	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	27,414	34,567	61,981	0	8.00
9.00	00900	HOUSEKEEPING	0	9,863	12,437	22,300	1,595	9.00
10.00	01000	DIETARY	0	44,779	56,463	101,242	800	10.00
11.00	01100	CAFETERIA	0	28,560	36,012	64,572	388	11.00
13.00	01300	NURSING ADMINISTRATION	75	7,664	9,664	17,403	1,150	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,550	44,137	55,653	111,340	109	16.00
18.00	01850	INSERVICE EDUCATION	0	42,070	53,046	95,116	2,656	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,657	483,575	609,750	1,098,982	10,903	30.00
31.00	03100	INTENSIVE CARE UNIT	531	82,289	103,760	186,580	3,472	31.00
40.00	04000	SUBPROVIDER - IPF	191	74,291	93,675	168,157	3,121	40.00
41.00	04100	SUBPROVIDER - IRF	17	88,320	111,364	199,701	1,447	41.00
43.00	04300	NURSERY	-17	8,083	10,191	18,257	319	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,948	195,274	246,225	444,447	5,524	50.00
51.00	05100	RECOVERY ROOM	0	12,194	15,375	27,569	1,032	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,379	55,602	70,110	128,091	1,374	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	101,171	127,569	228,740	1,735	54.00
54.01	05401	ULTRASOUND	0	3,143	3,963	7,106	254	54.01
54.02	05402	MAMMOGRAPHY	0	11,574	14,594	26,168	291	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	47,822	60,299	108,121	1,058	55.00
56.00	05600	RADIOISOTOPE	0	5,745	7,243	12,988	398	56.00
57.00	05700	CT SCAN	91	12,403	15,639	28,133	883	57.00
58.00	05800	MRI	10	8,052	10,152	18,214	439	58.00
59.00	05900	CARDIAC CATHETERIZATION	8	17,752	22,384	40,144	929	59.00
60.00	06000	LABORATORY	0	41,435	52,246	93,681	2,165	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,477	3,124	5,601	112	62.00
65.00	06500	RESPIRATORY THERAPY	19	12,689	16,000	28,708	1,843	65.00
66.00	06600	PHYSICAL THERAPY	452	105,174	132,616	238,242	2,018	66.00
69.00	06900	ELECTROCARDIOLOGY	0	16,970	21,398	38,368	869	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	8,439	10,641	19,080	99	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	29	65,737	82,889	148,655	601	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,787	26,211	46,998	2,675	73.00
74.00	07400	RENAL DIALYSIS	0	3,654	4,608	8,262	0	74.00
76.00	03020	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	14,903	18,792	33,695	596	76.01
76.02	03950	PRISON CLINIC	0	58,064	73,214	131,278	231	76.02
76.03	03951	WOUNDCARE	0	13,378	16,869	30,247	123	76.03
76.04	03952	OPIC	0	29,613	37,339	66,952	788	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,235	79,595	100,362	183,192	3,899	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,039,245	2,748,000	3,465,007	8,252,252	63,402	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,699	5,925	10,624	54	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OCCUPATIONAL MEDICINE	0	35,071	44,222	79,293	1,768	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	23,110	0	23,110	0	194.01
194.02	07952	SITTERS	14	0	0	14	415	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,039,259	2,810,880	3,515,154	8,365,293	65,639	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet B Part II | Date/Time Prepared: 1/25/2017 6:24 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,441,640					5.00
7.00	00700	OPERATION OF PLANT	144,848	1,609,016				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,231	22,649	100,861			8.00
9.00	00900	HOUSEKEEPING	44,908	8,149	7,284	84,236		9.00
10.00	01000	DIETARY	43,629	36,995	0	1,975	184,641	10.00
11.00	01100	CAFETERIA	11,853	23,595	0	1,259	0	11.00
13.00	01300	NURSING ADMINISTRATION	24,921	6,332	0	338	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	35,869	36,464	0	1,946	0	16.00
18.00	01850	INSERVICE EDUCATION	58,553	34,756	0	1,855	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	301,310	399,514	38,919	21,323	87,312	30.00
31.00	03100	INTENSIVE CARE UNIT	88,551	67,984	8,261	3,629	5,205	31.00
40.00	04000	SUBPROVIDER - IPF	76,155	61,377	4,806	3,276	26,909	40.00
41.00	04100	SUBPROVIDER - IRF	36,947	72,967	1,125	3,895	11,151	41.00
43.00	04300	NURSERY	8,453	6,678	0	356	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	144,746	161,329	8,261	8,611	0	50.00
51.00	05100	RECOVERY ROOM	23,544	10,074	0	538	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	44,973	45,937	1,563	2,452	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	59,054	83,584	4,900	4,461	0	54.00
54.01	05401	ULTRASOUND	6,172	2,597	0	139	0	54.01
54.02	05402	MAMMOGRAPHY	9,548	9,562	0	510	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	35,623	39,509	0	2,109	0	55.00
56.00	05600	RADIOISOTOPE	29,929	4,746	0	253	0	56.00
57.00	05700	CT SCAN	24,924	10,247	0	547	0	57.00
58.00	05800	MRI	12,195	6,652	0	355	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	25,174	14,666	0	783	0	59.00
60.00	06000	LABORATORY	87,986	34,232	0	1,827	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	17,849	2,047	0	109	0	62.00
65.00	06500	RESPIRATORY THERAPY	43,624	10,483	0	560	0	65.00
66.00	06600	PHYSICAL THERAPY	52,769	86,891	1,813	4,638	0	66.00
69.00	06900	ELECTROCARDIOLOGY	26,568	14,020	703	748	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,121	6,972	0	372	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	176,641	54,309	9,964	2,899	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	192,262	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	277,640	17,174	0	917	0	73.00
74.00	07400	RENAL DIALYSIS	23,354	3,019	0	161	0	74.00
76.00	03020	LITHOTRIPSY	4,701	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	20,076	12,312	0	657	0	76.01
76.02	03950	PRISON CLINIC	9,092	47,971	0	2,560	0	76.02
76.03	03951	WOUNDCARE	20,537	11,052	1,211	590	0	76.03
76.04	03952	OPIC	19,938	24,465	907	1,306	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	112,290	65,758	11,144	3,510	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,396,558	1,557,068	100,861	81,464	130,577	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,044	3,882	0	207	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OCCUPATIONAL MEDICINE	33,752	28,974	0	1,546	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	671	19,092	0	1,019	54,064	194.01
194.02	07952	SITTERS	8,615	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,441,640	1,609,016	100,861	84,236	184,641	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet B Part II Date/Time Prepared: 1/25/2017 6:24 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	
			11.00	13.00	16.00	18.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	101,667					11.00
13.00	01300	NURSING ADMINISTRATION	1,344	51,488				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	284	0	186,012			16.00
18.00	01850	INSERVICE EDUCATION	4,892	3,879	0	201,707		18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,104	18,619	6,827	54,718	2,060,531	30.00
31.00	03100	INTENSIVE CARE UNIT	5,687	4,684	2,570	14,406	391,029	31.00
40.00	04000	SUBPROVIDER - IPF	6,810	5,463	6,586	26,655	389,315	40.00
41.00	04100	SUBPROVIDER - IRF	2,398	1,908	641	3,097	335,277	41.00
43.00	04300	NURSERY	514	426	237	1,189	36,429	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,291	0	24,680	6,498	814,387	50.00
51.00	05100	RECOVERY ROOM	1,378	0	3,454	2,682	70,271	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,475	1,963	940	3,926	233,694	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,167	0	4,226	2,184	393,051	54.00
54.01	05401	ULTRASOUND	497	0	1,075	1,051	18,891	54.01
54.02	05402	MAMMOGRAPHY	580	0	708	2,157	49,524	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,610	1,276	4,648	3,318	197,272	55.00
56.00	05600	RADIOISOTOPE	539	0	3,613	359	52,825	56.00
57.00	05700	CT SCAN	1,704	0	13,862	2,461	82,761	57.00
58.00	05800	MRI	699	0	3,855	359	42,768	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,080	856	6,377	1,742	91,751	59.00
60.00	06000	LABORATORY	5,226	0	18,322	2,793	246,232	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	251	0	1,932	111	28,012	62.00
65.00	06500	RESPIRATORY THERAPY	3,249	2,576	5,423	4,590	101,056	65.00
66.00	06600	PHYSICAL THERAPY	2,649	0	2,090	8,129	399,239	66.00
69.00	06900	ELECTROCARDIOLOGY	1,798	1,426	4,485	1,908	90,893	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	180	143	455	138	30,560	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,610	0	11,579	0	406,258	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	5,493	0	197,755	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,006	0	29,651	0	379,061	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,620	0	36,416	74.00
76.00	03020	LITHOTRIPSY	0	0	376	0	5,077	76.00
76.01	03330	ENDOSCOPY	771	0	2,227	2,295	72,629	76.01
76.02	03950	PRISON CLINIC	400	0	103	0	191,635	76.02
76.03	03951	WOUNDCARE	199	317	976	664	65,916	76.03
76.04	03952	OPIC	1,423	1,129	1,805	0	118,713	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,641	5,762	15,176	52,369	459,741	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	97,456	50,427	186,012	199,799	8,088,969	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	160	0	0	0	16,971	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OCCUPATIONAL MEDICINE	2,771	0	0	1,576	149,680	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	97,956	194.01
194.02	07952	SITTERS	1,280	1,061	0	332	11,717	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	101,667	51,488	186,012	201,707	8,365,293	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet B Part II Date/Time Prepared: 1/25/2017 6:24 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
18.00	01850	INSERVICE EDUCATION			18.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	2,060,531	30.00
31.00	03100	INTENSIVE CARE UNIT	0	391,029	31.00
40.00	04000	SUBPROVIDER - IPF	0	389,315	40.00
41.00	04100	SUBPROVIDER - IRF	0	335,277	41.00
43.00	04300	NURSERY	0	36,429	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	814,387	50.00
51.00	05100	RECOVERY ROOM	0	70,271	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	233,694	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	393,051	54.00
54.01	05401	ULTRASOUND	0	18,891	54.01
54.02	05402	MAMMOGRAPHY	0	49,524	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	197,272	55.00
56.00	05600	RADIOISOTOPE	0	52,825	56.00
57.00	05700	CT SCAN	0	82,761	57.00
58.00	05800	MRI	0	42,768	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	91,751	59.00
60.00	06000	LABORATORY	0	246,232	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	28,012	62.00
65.00	06500	RESPIRATORY THERAPY	0	101,056	65.00
66.00	06600	PHYSICAL THERAPY	0	399,239	66.00
69.00	06900	ELECTROCARDIOLOGY	0	90,893	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	30,560	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	406,258	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	197,755	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	379,061	73.00
74.00	07400	RENAL DIALYSIS	0	36,416	74.00
76.00	03020	LITHOTRIPSY	0	5,077	76.00
76.01	03330	ENDOSCOPY	0	72,629	76.01
76.02	03950	PRISON CLINIC	0	191,635	76.02
76.03	03951	WOUNDCARE	0	65,916	76.03
76.04	03952	OPIC	0	118,713	76.04
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	459,741	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.00	09900	CMHC	0	0	99.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	8,088,969	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,971	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	OCCUPATIONAL MEDICINE	0	149,680	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	97,956	194.01
194.02	07952	SITTERS	0	11,717	194.02
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	8,365,293	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet B-1 | Date/Time Prepared: 1/25/2017 6:24 pm

			CAPITAL RELATED COSTS					
		Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FOOTAGE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	363,073					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		360,088				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,750	3,750	36,546,398			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,188	24,188	3,444,995	-17,716,589	84,138,072	5.00
7.00	00700	OPERATION OF PLANT	83,573	83,573	734,200	0	4,991,491	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,541	3,541	0	0	559,334	8.00
9.00	00900	HOUSEKEEPING	1,274	1,274	888,157	0	1,547,547	9.00
10.00	01000	DIETARY	5,784	5,784	445,285	0	1,503,469	10.00
11.00	01100	CAFETERIA	3,689	3,689	216,304	0	408,468	11.00
13.00	01300	NURSING ADMINISTRATION	990	990	640,362	0	858,766	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,701	5,701	60,894	0	1,236,049	16.00
18.00	01850	INSERVICE EDUCATION	5,434	5,434	1,478,973	0	2,017,746	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	62,462	62,462	6,070,555	0	10,381,938	30.00
31.00	03100	INTENSIVE CARE UNIT	10,629	10,629	1,933,027	0	3,051,469	31.00
40.00	04000	SUBPROVIDER - IPF	9,596	9,596	1,737,503	0	2,624,298	40.00
41.00	04100	SUBPROVIDER - IRF	11,408	11,408	805,441	0	1,273,186	41.00
43.00	04300	NURSERY	1,044	1,044	177,346	0	291,276	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,223	25,223	3,075,732	0	4,987,971	50.00
51.00	05100	RECOVERY ROOM	1,575	1,575	574,355	0	811,328	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,182	7,182	765,272	0	1,549,775	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,068	13,068	966,032	0	2,035,018	54.00
54.01	05401	ULTRASOUND	406	406	141,609	0	212,695	54.01
54.02	05402	MAMMOGRAPHY	1,495	1,495	161,823	0	329,035	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	6,177	6,177	589,007	0	1,227,586	55.00
56.00	05600	RADIOISOTOPE	742	742	221,699	0	1,031,364	56.00
57.00	05700	CT SCAN	1,602	1,602	491,549	0	858,875	57.00
58.00	05800	MRI	1,040	1,040	244,298	0	420,225	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,293	2,293	517,462	0	867,485	59.00
60.00	06000	LABORATORY	5,352	5,352	1,205,429	0	3,032,030	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	320	320	62,152	0	615,094	62.00
65.00	06500	RESPIRATORY THERAPY	1,639	1,639	1,026,185	0	1,503,280	65.00
66.00	06600	PHYSICAL THERAPY	13,585	13,585	1,123,703	0	1,818,418	66.00
69.00	06900	ELECTROCARDIOLOGY	2,192	2,192	483,814	0	915,527	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,090	1,090	55,025	0	107,553	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,491	8,491	334,641	0	6,087,090	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6,625,391	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,685	2,685	1,489,580	0	9,567,509	73.00
74.00	07400	RENAL DIALYSIS	472	472	0	0	804,795	74.00
76.00	03020	LITHOTRIPSY	0	0	0	0	162,003	76.00
76.01	03330	ENDOSCOPY	1,925	1,925	331,914	0	691,821	76.01
76.02	03950	PRISON CLINIC	7,500	7,500	128,644	0	313,325	76.02
76.03	03951	WOUNDCARE	1,728	1,728	68,596	0	707,716	76.03
76.04	03952	OPIC	3,825	3,825	438,578	0	687,068	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,281	10,281	2,170,762	0	3,869,534	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	354,951	354,951	35,300,903	-17,716,589	82,584,548	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	607	607	30,184	0	70,421	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OCCUPATIONAL MEDICINE	4,530	4,530	984,185	0	1,163,103	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	2,985	0	0	0	23,110	194.01
194.02	07952	SITTERS	0	0	231,126	0	296,890	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,810,880	3,515,154	7,276,108		17,716,589	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.741914	9.761930	0.199092		0.210566	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			65,639		2,441,640	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet B-1 | Date/Time Prepared: 1/25/2017 6:24 pm

		Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FOOTAGE)				
			1.00	2.00	4.00	5A	5.00	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001796		0.029019	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet B-1 | Date/Time Prepared: 1/25/2017 6:24 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MANHOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	251,562					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,541	12,906				8.00
9.00	00900	HOUSEKEEPING	1,274	932	246,747			9.00
10.00	01000	DIETARY	5,784	0	5,784	144,385		10.00
11.00	01100	CAFETERIA	3,689	0	3,689	0	1,063,238	11.00
13.00	01300	NURSING ADMINISTRATION	990	0	990	0	14,053	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,701	0	5,701	0	2,974	16.00
18.00	01850	INSERVICE EDUCATION	5,434	0	5,434	0	51,163	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	62,462	4,980	62,462	68,276	231,145	30.00
31.00	03100	INTENSIVE CARE UNIT	10,629	1,057	10,629	4,070	59,477	31.00
40.00	04000	SUBPROVIDER - IPF	9,596	615	9,596	21,042	71,223	40.00
41.00	04100	SUBPROVIDER - IRF	11,408	144	11,408	8,720	25,077	41.00
43.00	04300	NURSERY	1,044	0	1,044	0	5,380	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,223	1,057	25,223	0	107,622	50.00
51.00	05100	RECOVERY ROOM	1,575	0	1,575	0	14,412	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,182	200	7,182	0	25,886	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,068	627	13,068	0	43,576	54.00
54.01	05401	ULTRASOUND	406	0	406	0	5,200	54.01
54.02	05402	MAMMOGRAPHY	1,495	0	1,495	0	6,061	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	6,177	0	6,177	0	16,834	55.00
56.00	05600	RADIOISOTOPE	742	0	742	0	5,641	56.00
57.00	05700	CT SCAN	1,602	0	1,602	0	17,822	57.00
58.00	05800	MRI	1,040	0	1,040	0	7,315	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,293	0	2,293	0	11,290	59.00
60.00	06000	LABORATORY	5,352	0	5,352	0	54,652	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	320	0	320	0	2,622	62.00
65.00	06500	RESPIRATORY THERAPY	1,639	0	1,639	0	33,977	65.00
66.00	06600	PHYSICAL THERAPY	13,585	232	13,585	0	27,707	66.00
69.00	06900	ELECTROCARDIOLOGY	2,192	90	2,192	0	18,807	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,090	0	1,090	0	1,882	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,491	1,275	8,491	0	16,839	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,685	0	2,685	0	41,898	73.00
74.00	07400	RENAL DIALYSIS	472	0	472	0	0	74.00
76.00	03020	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	1,925	0	1,925	0	8,062	76.01
76.02	03950	PRISON CLINIC	7,500	0	7,500	0	4,187	76.02
76.03	03951	WOUNDCARE	1,728	155	1,728	0	2,078	76.03
76.04	03952	OPIC	3,825	116	3,825	0	14,885	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,281	1,426	10,281	0	69,449	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	243,440	12,906	238,625	102,108	1,019,196	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	607	0	607	0	1,676	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OCCUPATIONAL MEDICINE	4,530	0	4,530	0	28,983	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	2,985	0	2,985	42,277	0	194.01
194.02	07952	SITTERS	0	0	0	0	13,383	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,042,529	762,166	1,959,049	2,004,902	612,376	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.020039	59.055168	7.939505	13.885805	0.575954	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,609,016	100,861	84,236	184,641	101,667	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.396101	7.815047	0.341386	1.278810	0.095620	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet B-1 | Date/Time Prepared: 1/25/2017 6:24 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	OTHER GENERAL SERVICE INSERVICE EDUCATION (TIME SPENT)		
			13.00	16.00	18.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	679,124				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	633,950,480			16.00
18.00	01850	INSERVICE EDUCATION	51,163	0	7,295		18.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	245,597	23,298,971	1,979		30.00
31.00	03100	INTENSIVE CARE UNIT	61,778	8,770,558	521		31.00
40.00	04000	SUBPROVIDER - IPF	72,058	22,479,135	964		40.00
41.00	04100	SUBPROVIDER - IRF	25,169	2,186,183	112		41.00
43.00	04300	NURSERY	5,617	809,710	43		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	84,231,176	235		50.00
51.00	05100	RECOVERY ROOM	0	11,787,427	97		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,886	3,207,087	142		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,422,183	79		54.00
54.01	05401	ULTRASOUND	0	3,667,814	38		54.01
54.02	05402	MAMMOGRAPHY	0	2,415,287	78		54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	16,834	15,862,669	120		55.00
56.00	05600	RADIOISOTOPE	0	12,331,906	13		56.00
57.00	05700	CT SCAN	0	47,309,128	89		57.00
58.00	05800	MRI	0	13,158,459	13		58.00
59.00	05900	CARDIAC CATHETERIZATION	11,290	21,764,114	63		59.00
60.00	06000	LABORATORY	0	62,531,829	101		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	6,593,461	4		62.00
65.00	06500	RESPIRATORY THERAPY	33,977	18,509,531	166		65.00
66.00	06600	PHYSICAL THERAPY	0	7,131,902	294		66.00
69.00	06900	ELECTROCARDIOLOGY	18,807	15,306,627	69		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,882	1,551,414	5		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	39,517,121	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,746,420	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100,305,684	0		73.00
74.00	07400	RENAL DIALYSIS	0	5,530,574	0		74.00
76.00	03020	LITHOTRIPSY	0	1,284,350	0		76.00
76.01	03330	ENDOSCOPY	0	7,601,343	83		76.01
76.02	03950	PRISON CLINIC	0	350,310	0		76.02
76.03	03951	WOUNDCARE	4,187	3,331,924	24		76.03
76.04	03952	OPIC	14,885	6,162,086	0		76.04
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	75,998	51,794,097	1,894		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		OTHER REIMBURSABLE COST CENTERS					
99.00	09900	CMHC	0	0	0		99.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	665,128	633,950,480	7,226		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	OCCUPATIONAL MEDICINE	0	0	57		194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.01
194.02	07952	SITTERS	13,996	0	12		194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,079,327	1,680,233	2,727,064		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.589293	0.002650	373.826456		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	51,488	186,012	201,707		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet B-1 | Date/Time Prepared: 1/25/2017 6:24 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	OTHER GENERAL SERVICE INSERVICE EDUCATION (TIME SPENT)		
			13.00	16.00	18.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	0.075815	0.000293	27.650034		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet C Part I | Date/Time Prepared: 1/25/2017 6:24 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
					Costs			
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,131,414		17,131,414	23,377	17,154,791	30.00
31.00	03100	INTENSIVE CARE UNIT	4,503,084		4,503,084	0	4,503,084	31.00
40.00	04000	SUBPROVIDER - IPF	4,387,554		4,387,554	0	4,387,554	40.00
41.00	04100	SUBPROVIDER - IRF	2,137,565		2,137,565	0	2,137,565	41.00
43.00	04300	NURSERY	416,222		416,222	0	416,222	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,279,851		7,279,851	3,458	7,283,309	50.00
51.00	05100	RECOVERY ROOM	1,108,302		1,108,302	0	1,108,302	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,235,081		2,235,081	0	2,235,081	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,011,048		3,011,048	0	3,011,048	54.00
54.01	05401	ULTRASOUND	297,376		297,376	0	297,376	54.01
54.02	05402	MAMMOGRAPHY	485,149		485,149	0	485,149	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,806,833		1,806,833	0	1,806,833	55.00
56.00	05600	RADIOISOTOPE	1,313,037		1,313,037	0	1,313,037	56.00
57.00	05700	CT SCAN	1,259,829		1,259,829	0	1,259,829	57.00
58.00	05800	MRI	585,891		585,891	0	585,891	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,229,103		1,229,103	0	1,229,103	59.00
60.00	06000	LABORATORY	4,076,461		4,076,461	0	4,076,461	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	775,317		775,317	0	775,317	62.00
65.00	06500	RESPIRATORY THERAPY	2,056,875	0	2,056,875	0	2,056,875	65.00
66.00	06600	PHYSICAL THERAPY	2,793,949	0	2,793,949	19,424	2,813,373	66.00
69.00	06900	ELECTROCARDIOLOGY	1,290,755		1,290,755	11,521	1,302,276	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	175,091		175,091	0	175,091	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,829,905		7,829,905	0	7,829,905	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,070,151		8,070,151	0	8,070,151	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,958,115		11,958,115	0	11,958,115	73.00
74.00	07400	RENAL DIALYSIS	1,003,997		1,003,997	0	1,003,997	74.00
76.00	03020	LITHOTRIPSY	199,519		199,519	0	199,519	76.00
76.01	03330	ENDOSCOPY	954,833		954,833	0	954,833	76.01
76.02	03950	PRISON CLINIC	622,337		622,337	0	622,337	76.02
76.03	03951	WOUNDCARE	946,770		946,770	8,697	955,467	76.03
76.04	03952	OPIC	1,009,397		1,009,397	40,440	1,049,837	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,103,178		6,103,178	34,218	6,137,396	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,030,708		2,030,708		2,030,708	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0		0		0	99.00
200.00		Subtotal (see instructions)	101,084,697	0	101,084,697	141,135	101,225,832	200.00
201.00		Less Observation Beds	2,030,708		2,030,708		2,030,708	201.00
202.00		Total (see instructions)	99,053,989	0	99,053,989	141,135	99,195,124	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet C Part I Date/Time Prepared: 1/25/2017 6:24 pm

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		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	20,626,812		20,626,812			30.00
31.00	03100	INTENSIVE CARE UNIT	8,770,558		8,770,558			31.00
40.00	04000	SUBPROVIDER - IPF	22,479,135		22,479,135			40.00
41.00	04100	SUBPROVIDER - IRF	2,186,183		2,186,183			41.00
43.00	04300	NURSERY	809,710		809,710			43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	39,340,180	44,890,996	84,231,176	0.086427	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,274,893	7,512,534	11,787,427	0.094024	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,079,953	127,134	3,207,087	0.696919	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,592,832	9,829,351	14,422,183	0.208779	0.000000	54.00
54.01	05401	ULTRASOUND	869,846	2,797,968	3,667,814	0.081077	0.000000	54.01
54.02	05402	MAMMOGRAPHY	4,219	2,411,068	2,415,287	0.200866	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,216,021	14,646,648	15,862,669	0.113905	0.000000	55.00
56.00	05600	RADIOISOTOPE	1,155,116	11,176,790	12,331,906	0.106475	0.000000	56.00
57.00	05700	CT SCAN	15,789,893	31,519,235	47,309,128	0.026630	0.000000	57.00
58.00	05800	MRI	3,754,489	9,403,970	13,158,459	0.044526	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	12,541,213	9,222,901	21,764,114	0.056474	0.000000	59.00
60.00	06000	LABORATORY	30,182,797	32,349,032	62,531,829	0.065190	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,318,870	1,274,591	6,593,461	0.117589	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	17,433,379	1,076,152	18,509,531	0.111125	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,048,024	2,083,878	7,131,902	0.391754	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	8,229,831	7,076,796	15,306,627	0.084327	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	662,544	888,870	1,551,414	0.112859	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,955,166	15,561,955	39,517,121	0.198140	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,174,242	8,572,178	18,746,420	0.430490	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,483,044	38,822,640	100,305,684	0.119217	0.000000	73.00
74.00	07400	RENAL DIALYSIS	5,453,301	77,273	5,530,574	0.181536	0.000000	74.00
76.00	03020	LITHOTRIPSY	0	1,284,350	1,284,350	0.155346	0.000000	76.00
76.01	03330	ENDOSCOPY	2,171,660	5,429,683	7,601,343	0.125614	0.000000	76.01
76.02	03950	PRISON CLINIC	1,236	349,074	350,310	1.776532	0.000000	76.02
76.03	03951	WOUNDCARE	58,419	3,273,505	3,331,924	0.284151	0.000000	76.03
76.04	03952	OPIC	74,183	6,087,903	6,162,086	0.163808	0.000000	76.04
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	15,138,826	36,655,271	51,794,097	0.117835	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	598,366	2,073,793	2,672,159	0.759950	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0			99.00
200.00		Subtotal (see instructions)	327,474,941	306,475,539	633,950,480			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	327,474,941	306,475,539	633,950,480			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet C Part I Date/Time Prepared: 1/25/2017 6:24 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.086468	50.00
51.00	05100	RECOVERY ROOM	0.094024	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.696919	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208779	54.00
54.01	05401	ULTRASOUND	0.081077	54.01
54.02	05402	MAMMOGRAPHY	0.200866	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.113905	55.00
56.00	05600	RADIOISOTOPE	0.106475	56.00
57.00	05700	CT SCAN	0.026630	57.00
58.00	05800	MRI	0.044526	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.056474	59.00
60.00	06000	LABORATORY	0.065190	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.117589	62.00
65.00	06500	RESPIRATORY THERAPY	0.111125	65.00
66.00	06600	PHYSICAL THERAPY	0.394477	66.00
69.00	06900	ELECTROCARDIOLOGY	0.085079	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.112859	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.198140	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.430490	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.119217	73.00
74.00	07400	RENAL DIALYSIS	0.181536	74.00
76.00	03020	LITHOTRIPSY	0.155346	76.00
76.01	03330	ENDOSCOPY	0.125614	76.01
76.02	03950	PRISON CLINIC	1.776532	76.02
76.03	03951	WOUNDCARE	0.286761	76.03
76.04	03952	OPIC	0.170370	76.04
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.118496	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.759950	92.00
		OTHER REIMBURSABLE COST CENTERS		
99.00	09900	CMHC		99.00
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: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet C Part I | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,131,414		17,131,414	23,377	17,154,791	30.00
31.00	03100	INTENSIVE CARE UNIT	4,503,084		4,503,084	0	4,503,084	31.00
40.00	04000	SUBPROVIDER - IPF	4,387,554		4,387,554	0	4,387,554	40.00
41.00	04100	SUBPROVIDER - IRF	2,137,565		2,137,565	0	2,137,565	41.00
43.00	04300	NURSERY	416,222		416,222	0	416,222	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,279,851		7,279,851	3,458	7,283,309	50.00
51.00	05100	RECOVERY ROOM	1,108,302		1,108,302	0	1,108,302	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,235,081		2,235,081	0	2,235,081	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,011,048		3,011,048	0	3,011,048	54.00
54.01	05401	ULTRASOUND	297,376		297,376	0	297,376	54.01
54.02	05402	MAMMOGRAPHY	485,149		485,149	0	485,149	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,806,833		1,806,833	0	1,806,833	55.00
56.00	05600	RADIOISOTOPE	1,313,037		1,313,037	0	1,313,037	56.00
57.00	05700	CT SCAN	1,259,829		1,259,829	0	1,259,829	57.00
58.00	05800	MRI	585,891		585,891	0	585,891	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,229,103		1,229,103	0	1,229,103	59.00
60.00	06000	LABORATORY	4,076,461		4,076,461	0	4,076,461	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	775,317		775,317	0	775,317	62.00
65.00	06500	RESPIRATORY THERAPY	2,056,875	0	2,056,875	0	2,056,875	65.00
66.00	06600	PHYSICAL THERAPY	2,793,949	0	2,793,949	19,424	2,813,373	66.00
69.00	06900	ELECTROCARDIOLOGY	1,290,755		1,290,755	11,521	1,302,276	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	175,091		175,091	0	175,091	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,829,905		7,829,905	0	7,829,905	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,070,151		8,070,151	0	8,070,151	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,958,115		11,958,115	0	11,958,115	73.00
74.00	07400	RENAL DIALYSIS	1,003,997		1,003,997	0	1,003,997	74.00
76.00	03020	LITHOTRIPSY	199,519		199,519	0	199,519	76.00
76.01	03330	ENDOSCOPY	954,833		954,833	0	954,833	76.01
76.02	03950	PRISON CLINIC	622,337		622,337	0	622,337	76.02
76.03	03951	WOUNDCARE	946,770		946,770	8,697	955,467	76.03
76.04	03952	OPIC	1,009,397		1,009,397	40,440	1,049,837	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,103,178		6,103,178	34,218	6,137,396	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,030,708		2,030,708		2,030,708	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0		0		0	99.00
200.00		Subtotal (see instructions)	101,084,697	0	101,084,697	141,135	101,225,832	200.00
201.00		Less Observation Beds	2,030,708		2,030,708		2,030,708	201.00
202.00		Total (see instructions)	99,053,989	0	99,053,989	141,135	99,195,124	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet C Part I | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Hospital | Cost

		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	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,626,812		20,626,812			30.00
31.00	03100	INTENSIVE CARE UNIT	8,770,558		8,770,558			31.00
40.00	04000	SUBPROVIDER - IPF	22,479,135		22,479,135			40.00
41.00	04100	SUBPROVIDER - IRF	2,186,183		2,186,183			41.00
43.00	04300	NURSERY	809,710		809,710			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	39,340,180	44,890,996	84,231,176	0.086427	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,274,893	7,512,534	11,787,427	0.094024	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,079,953	127,134	3,207,087	0.696919	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,592,832	9,829,351	14,422,183	0.208779	0.000000	54.00
54.01	05401	ULTRASOUND	869,846	2,797,968	3,667,814	0.081077	0.000000	54.01
54.02	05402	MAMMOGRAPHY	4,219	2,411,068	2,415,287	0.200866	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,216,021	14,646,648	15,862,669	0.113905	0.000000	55.00
56.00	05600	RADIOISOTOPE	1,155,116	11,176,790	12,331,906	0.106475	0.000000	56.00
57.00	05700	CT SCAN	15,789,893	31,519,235	47,309,128	0.026630	0.000000	57.00
58.00	05800	MRI	3,754,489	9,403,970	13,158,459	0.044526	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	12,541,213	9,222,901	21,764,114	0.056474	0.000000	59.00
60.00	06000	LABORATORY	30,182,797	32,349,032	62,531,829	0.065190	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,318,870	1,274,591	6,593,461	0.117589	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	17,433,379	1,076,152	18,509,531	0.111125	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,048,024	2,083,878	7,131,902	0.391754	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	8,229,831	7,076,796	15,306,627	0.084327	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	662,544	888,870	1,551,414	0.112859	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,955,166	15,561,955	39,517,121	0.198140	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,174,242	8,572,178	18,746,420	0.430490	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,483,044	38,822,640	100,305,684	0.119217	0.000000	73.00
74.00	07400	RENAL DIALYSIS	5,453,301	77,273	5,530,574	0.181536	0.000000	74.00
76.00	03020	LITHOTRIPSY	0	1,284,350	1,284,350	0.155346	0.000000	76.00
76.01	03330	ENDOSCOPY	2,171,660	5,429,683	7,601,343	0.125614	0.000000	76.01
76.02	03950	PRISON CLINIC	1,236	349,074	350,310	1.776532	0.000000	76.02
76.03	03951	WOUNDCARE	58,419	3,273,505	3,331,924	0.284151	0.000000	76.03
76.04	03952	OPIC	74,183	6,087,903	6,162,086	0.163808	0.000000	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	15,138,826	36,655,271	51,794,097	0.117835	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	598,366	2,073,793	2,672,159	0.759950	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0			99.00
200.00		Subtotal (see instructions)	327,474,941	306,475,539	633,950,480			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	327,474,941	306,475,539	633,950,480			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet C Part I Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
54.02	05402	MAMMOGRAPHY	0.000000	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03020	LITHOTRIPSY	0.000000	76.00
76.01	03330	ENDOSCOPY	0.000000	76.01
76.02	03950	PRISON CLINIC	0.000000	76.02
76.03	03951	WOUNDCARE	0.000000	76.03
76.04	03952	OPIC	0.000000	76.04
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
99.00	09900	CMHC		99.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet C Part II | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,279,851	814,387	6,465,464	0	0	50.00
51.00	05100	RECOVERY ROOM	1,108,302	70,271	1,038,031	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,235,081	233,694	2,001,387	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,011,048	393,051	2,617,997	0	0	54.00
54.01	05401	ULTRASOUND	297,376	18,891	278,485	0	0	54.01
54.02	05402	MAMMOGRAPHY	485,149	49,524	435,625	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,806,833	197,272	1,609,561	0	0	55.00
56.00	05600	RADIOISOTOPE	1,313,037	52,825	1,260,212	0	0	56.00
57.00	05700	CT SCAN	1,259,829	82,761	1,177,068	0	0	57.00
58.00	05800	MRI	585,891	42,768	543,123	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,229,103	91,751	1,137,352	0	0	59.00
60.00	06000	LABORATORY	4,076,461	246,232	3,830,229	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	775,317	28,012	747,305	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,056,875	101,056	1,955,819	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,793,949	399,239	2,394,710	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,290,755	90,893	1,199,862	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	175,091	30,560	144,531	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,829,905	406,258	7,423,647	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,070,151	197,755	7,872,396	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,958,115	379,061	11,579,054	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,003,997	36,416	967,581	0	0	74.00
76.00	03020	LITHOTRIPSY	199,519	5,077	194,442	0	0	76.00
76.01	03330	ENDOSCOPY	954,833	72,629	882,204	0	0	76.01
76.02	03950	PRISON CLINIC	622,337	191,635	430,702	0	0	76.02
76.03	03951	WOUNDCARE	946,770	65,916	880,854	0	0	76.03
76.04	03952	OPIC	1,009,397	118,713	890,684	0	0	76.04
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	6,103,178	459,741	5,643,437	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,030,708	243,916	1,786,792	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	0	99.00
200.00		Subtotal (sum of lines 50 thru 199)	72,508,858	5,120,304	67,388,554	0	0	200.00
201.00		Less Observation Beds	2,030,708	243,916	1,786,792	0	0	201.00
202.00		Total (line 200 minus line 201)	70,478,150	4,876,388	65,601,762	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet C Part II | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	7,279,851	84,231,176	0.086427	50.00
51.00	05100	RECOVERY ROOM	1,108,302	11,787,427	0.094024	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,235,081	3,207,087	0.696919	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,011,048	14,422,183	0.208779	54.00
54.01	05401	ULTRASOUND	297,376	3,667,814	0.081077	54.01
54.02	05402	MAMMOGRAPHY	485,149	2,415,287	0.200866	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	1,806,833	15,862,669	0.113905	55.00
56.00	05600	RADIOISOTOPE	1,313,037	12,331,906	0.106475	56.00
57.00	05700	CT SCAN	1,259,829	47,309,128	0.026630	57.00
58.00	05800	MRI	585,891	13,158,459	0.044526	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,229,103	21,764,114	0.056474	59.00
60.00	06000	LABORATORY	4,076,461	62,531,829	0.065190	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	775,317	6,593,461	0.117589	62.00
65.00	06500	RESPIRATORY THERAPY	2,056,875	18,509,531	0.111125	65.00
66.00	06600	PHYSICAL THERAPY	2,793,949	7,131,902	0.391754	66.00
69.00	06900	ELECTROCARDIOLOGY	1,290,755	15,306,627	0.084327	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	175,091	1,551,414	0.112859	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,829,905	39,517,121	0.198140	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,070,151	18,746,420	0.430490	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,958,115	100,305,684	0.119217	73.00
74.00	07400	RENAL DIALYSIS	1,003,997	5,530,574	0.181536	74.00
76.00	03020	LITHOTRIPSY	199,519	1,284,350	0.155346	76.00
76.01	03330	ENDOSCOPY	954,833	7,601,343	0.125614	76.01
76.02	03950	PRISON CLINIC	622,337	350,310	1.776532	76.02
76.03	03951	WOUNDCARE	946,770	3,331,924	0.284151	76.03
76.04	03952	OPIC	1,009,397	6,162,086	0.163808	76.04
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	6,103,178	51,794,097	0.117835	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,030,708	2,672,159	0.759950	92.00
	OTHER REIMBURSABLE COST CENTERS					
99.00	09900	CMHC	0	0	0.000000	99.00
200.00		Subtotal (sum of lines 50 thru 199)	72,508,858	579,078,082		200.00
201.00		Less Observation Beds	2,030,708	0		201.00
202.00		Total (line 200 minus line 201)	70,478,150	579,078,082		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 150046	Period: From 09/01/2015 To 08/31/2016	Worksheet D Part I Date/Time Prepared: 1/25/2017 6:24 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,060,531	0	2,060,531	21,871	94.21	30.00
31.00	INTENSIVE CARE UNIT	391,029		391,029	3,365	116.20	31.00
40.00	SUBPROVIDER - IPF	389,315	0	389,315	6,404	60.79	40.00
41.00	SUBPROVIDER - IRF	335,277	0	335,277	1,827	183.51	41.00
43.00	NURSERY	36,429		36,429	563	64.71	43.00
200.00	Total (lines 30-199)	3,212,581		3,212,581	34,030		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	10,985	1,034,897	30.00
31.00	INTENSIVE CARE UNIT	1,767	205,325	31.00
40.00	SUBPROVIDER - IPF	1,426	86,687	40.00
41.00	SUBPROVIDER - IRF	1,143	209,752	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	15,321	1,536,661	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part II Date/Time Prepared: 1/25/2017 6:24 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	814,387	84,231,176	0.009668	18,083,696	174,833	50.00
51.00	05100	RECOVERY ROOM	70,271	11,787,427	0.005962	1,965,163	11,716	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	233,694	3,207,087	0.072868	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	393,051	14,422,183	0.027253	2,440,979	66,524	54.00
54.01	05401	ULTRASOUND	18,891	3,667,814	0.005150	426,727	2,198	54.01
54.02	05402	MAMMOGRAPHY	49,524	2,415,287	0.020504	3,268	67	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	197,272	15,862,669	0.012436	553,752	6,886	55.00
56.00	05600	RADIOISOTOPE	52,825	12,331,906	0.004284	670,480	2,872	56.00
57.00	05700	CT SCAN	82,761	47,309,128	0.001749	7,766,827	13,584	57.00
58.00	05800	MRI	42,768	13,158,459	0.003250	1,810,333	5,884	58.00
59.00	05900	CARDIAC CATHETERIZATION	91,751	21,764,114	0.004216	6,427,905	27,100	59.00
60.00	06000	LABORATORY	246,232	62,531,829	0.003938	15,271,598	60,140	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	28,012	6,593,461	0.004248	2,784,324	11,828	62.00
65.00	06500	RESPIRATORY THERAPY	101,056	18,509,531	0.005460	10,355,163	56,539	65.00
66.00	06600	PHYSICAL THERAPY	399,239	7,131,902	0.055979	1,483,582	83,049	66.00
69.00	06900	ELECTROCARDIOLOGY	90,893	15,306,627	0.005938	4,831,728	28,691	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	30,560	1,551,414	0.019698	383,246	7,549	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	406,258	39,517,121	0.010281	12,471,728	128,222	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	197,755	18,746,420	0.010549	5,672,198	59,836	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	379,061	100,305,684	0.003779	30,595,601	115,621	73.00
74.00	07400	RENAL DIALYSIS	36,416	5,530,574	0.006584	3,241,604	21,343	74.00
76.00	03020	LITHOTRIPSY	5,077	1,284,350	0.003953	0	0	76.00
76.01	03330	ENDOSCOPY	72,629	7,601,343	0.009555	1,254,111	11,983	76.01
76.02	03950	PRISON CLINIC	191,635	350,310	0.547044	0	0	76.02
76.03	03951	WOUNDCARE	65,916	3,331,924	0.019783	40,595	803	76.03
76.04	03952	OPIC	118,713	6,162,086	0.019265	54,645	1,053	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	459,741	51,794,097	0.008876	6,973,980	61,901	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	243,916	2,672,159	0.091280	380,256	34,710	92.00
200.00		Total (lines 50-199)	5,120,304	579,078,082		135,943,489	994,932	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part III Date/Time Prepared: 1/25/2017 6:24 pm

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		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			6.00	7.00	8.00	9.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,871	0.00	10,985	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,365	0.00	1,767	0	31.00
40.00	04000	SUBPROVIDER - IPF	6,404	0.00	1,426	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,827	0.00	1,143	0	41.00
43.00	04300	NURSERY	563	0.00	0	0	43.00
200.00		Total (lines 30-199)	34,030		15,321	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part IV Date/Time Prepared: 1/25/2017 6:24 pm

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		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03950	PRISON CLINIC	0	0	0	0	0	76.02
76.03	03951	WOUNDCARE	0	0	0	0	0	76.03
76.04	03952	OPIC	0	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
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: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part IV Date/Time Prepared: 1/25/2017 6:24 pm

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		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	84,231,176	0.000000	0.000000	18,083,696	50.00
51.00	05100	RECOVERY ROOM	0	11,787,427	0.000000	0.000000	1,965,163	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,207,087	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,422,183	0.000000	0.000000	2,440,979	54.00
54.01	05401	ULTRASOUND	0	3,667,814	0.000000	0.000000	426,727	54.01
54.02	05402	MAMMOGRAPHY	0	2,415,287	0.000000	0.000000	3,268	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	15,862,669	0.000000	0.000000	553,752	55.00
56.00	05600	RADIOISOTOPE	0	12,331,906	0.000000	0.000000	670,480	56.00
57.00	05700	CT SCAN	0	47,309,128	0.000000	0.000000	7,766,827	57.00
58.00	05800	MRI	0	13,158,459	0.000000	0.000000	1,810,333	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	21,764,114	0.000000	0.000000	6,427,905	59.00
60.00	06000	LABORATORY	0	62,531,829	0.000000	0.000000	15,271,598	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	6,593,461	0.000000	0.000000	2,784,324	62.00
65.00	06500	RESPIRATORY THERAPY	0	18,509,531	0.000000	0.000000	10,355,163	65.00
66.00	06600	PHYSICAL THERAPY	0	7,131,902	0.000000	0.000000	1,483,582	66.00
69.00	06900	ELECTROCARDIOLOGY	0	15,306,627	0.000000	0.000000	4,831,728	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,551,414	0.000000	0.000000	383,246	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	39,517,121	0.000000	0.000000	12,471,728	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,746,420	0.000000	0.000000	5,672,198	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100,305,684	0.000000	0.000000	30,595,601	73.00
74.00	07400	RENAL DIALYSIS	0	5,530,574	0.000000	0.000000	3,241,604	74.00
76.00	03020	LITHOTRIPSY	0	1,284,350	0.000000	0.000000	0	76.00
76.01	03330	ENDOSCOPY	0	7,601,343	0.000000	0.000000	1,254,111	76.01
76.02	03950	PRISON CLINIC	0	350,310	0.000000	0.000000	0	76.02
76.03	03951	WOUNDCARE	0	3,331,924	0.000000	0.000000	40,595	76.03
76.04	03952	OPIC	0	6,162,086	0.000000	0.000000	54,645	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	51,794,097	0.000000	0.000000	6,973,980	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,672,159	0.000000	0.000000	380,256	92.00
200.00		Total (lines 50-199)	0	579,078,082			135,943,489	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part IV | Date/Time Prepared: 1/25/2017 6:24 pm

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		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	13,154,700	0	50.00
51.00	05100	RECOVERY ROOM	0	1,982,755	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,230,062	0	54.00
54.01	05401	ULTRASOUND	0	559,995	0	54.01
54.02	05402	MAMMOGRAPHY	0	167,545	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	8,037,166	0	55.00
56.00	05600	RADIOISOTOPE	0	4,688,428	0	56.00
57.00	05700	CT SCAN	0	9,205,263	0	57.00
58.00	05800	MRI	0	2,693,990	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	4,926,491	0	59.00
60.00	06000	LABORATORY	0	6,157,367	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	424,430	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	217,005	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,730	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,289,592	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	229,104	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,944,185	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,481,160	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,892,847	0	73.00
74.00	07400	RENAL DIALYSIS	0	36,523	0	74.00
76.00	03020	LITHOTRIPSY	0	437,406	0	76.00
76.01	03330	ENDOSCOPY	0	2,069,065	0	76.01
76.02	03950	PRISON CLINIC	0	0	0	76.02
76.03	03951	WOUNDCARE	0	1,355,215	0	76.03
76.04	03952	OPIC	0	2,429,662	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	6,424,781	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	344,236	0	92.00
200.00		Total (lines 50-199)	0	92,383,703	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part V Date/Time Prepared: 1/25/2017 6:24 pm

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		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.086427	13,154,700	0	0	1,136,921	50.00
51.00	05100	RECOVERY ROOM	0.094024	1,982,755	0	0	186,427	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.696919	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208779	2,230,062	0	0	465,590	54.00
54.01	05401	ULTRASOUND	0.081077	559,995	0	0	45,403	54.01
54.02	05402	MAMMOGRAPHY	0.200866	167,545	0	0	33,654	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.113905	8,037,166	0	0	915,473	55.00
56.00	05600	RADIOISOTOPE	0.106475	4,688,428	0	0	499,200	56.00
57.00	05700	CT SCAN	0.026630	9,205,263	0	0	245,136	57.00
58.00	05800	MRI	0.044526	2,693,990	0	0	119,953	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.056474	4,926,491	0	0	278,219	59.00
60.00	06000	LABORATORY	0.065190	6,157,367	664	0	401,399	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.117589	424,430	0	0	49,908	62.00
65.00	06500	RESPIRATORY THERAPY	0.111125	217,005	0	0	24,115	65.00
66.00	06600	PHYSICAL THERAPY	0.391754	4,730	0	0	1,853	66.00
69.00	06900	ELECTROCARDIOLOGY	0.084327	2,289,592	0	0	193,074	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.112859	229,104	0	0	25,856	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.198140	4,944,185	0	0	979,641	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.430490	3,481,160	0	0	1,498,605	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.119217	13,892,847	0	133,213	1,656,264	73.00
74.00	07400	RENAL DIALYSIS	0.181536	36,523	0	0	6,630	74.00
76.00	03020	LITHOTRIPSY	0.155346	437,406	0	0	67,949	76.00
76.01	03330	ENDOSCOPY	0.125614	2,069,065	0	0	259,904	76.01
76.02	03950	PRISON CLINIC	1.776532	0	0	0	0	76.02
76.03	03951	WOUNDCARE	0.284151	1,355,215	0	0	385,086	76.03
76.04	03952	OPIC	0.163808	2,429,662	0	0	397,998	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.117835	6,424,781	0	0	757,064	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.759950	344,236	0	0	261,602	92.00
200.00		Subtotal (see instructions)		92,383,703	664	133,213	10,892,924	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		92,383,703	664	133,213	10,892,924	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part V Date/Time Prepared: 1/25/2017 6:24 pm

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		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ULTRASOUND	0	0	54.01
54.02	05402	MAMMOGRAPHY	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	43	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,881	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03020	LITHOTRIPSY	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	76.01
76.02	03950	PRISON CLINIC	0	0	76.02
76.03	03951	WOUNDCARE	0	0	76.03
76.04	03952	OPIC	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	43	15,881	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	43	15,881	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150046 | Component CCN: 15S046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part II | Date/Time Prepared: 1/25/2017 6:24 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	814,387	84,231,176	0.009668	0	0	50.00
51.00	05100	RECOVERY ROOM	70,271	11,787,427	0.005962	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	233,694	3,207,087	0.072868	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	393,051	14,422,183	0.027253	21,821	595	54.00
54.01	05401	ULTRASOUND	18,891	3,667,814	0.005150	0	0	54.01
54.02	05402	MAMMOGRAPHY	49,524	2,415,287	0.020504	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	197,272	15,862,669	0.012436	0	0	55.00
56.00	05600	RADIOISOTOPE	52,825	12,331,906	0.004284	0	0	56.00
57.00	05700	CT SCAN	82,761	47,309,128	0.001749	35,006	61	57.00
58.00	05800	MRI	42,768	13,158,459	0.003250	17,192	56	58.00
59.00	05900	CARDIAC CATHETERIZATION	91,751	21,764,114	0.004216	0	0	59.00
60.00	06000	LABORATORY	246,232	62,531,829	0.003938	489,243	1,927	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	28,012	6,593,461	0.004248	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	101,056	18,509,531	0.005460	53,065	290	65.00
66.00	06600	PHYSICAL THERAPY	399,239	7,131,902	0.055979	4,995	280	66.00
69.00	06900	ELECTROCARDIOLOGY	90,893	15,306,627	0.005938	9,889	59	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	30,560	1,551,414	0.019698	5,541	109	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	406,258	39,517,121	0.010281	6,284	65	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	197,755	18,746,420	0.010549	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	379,061	100,305,684	0.003779	560,710	2,119	73.00
74.00	07400	RENAL DIALYSIS	36,416	5,530,574	0.006584	0	0	74.00
76.00	03020	LITHOTRIPSY	5,077	1,284,350	0.003953	0	0	76.00
76.01	03330	ENDOSCOPY	72,629	7,601,343	0.009555	0	0	76.01
76.02	03950	PRISON CLINIC	191,635	350,310	0.547044	0	0	76.02
76.03	03951	WOUNDCARE	65,916	3,331,924	0.019783	0	0	76.03
76.04	03952	OPIC	118,713	6,162,086	0.019265	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	459,741	51,794,097	0.008876	283,091	2,513	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,672,159	0.000000	2,586	0	92.00
200.00		Total (lines 50-199)	4,876,388	579,078,082		1,489,423	8,074	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150046 Component CCN: 15S046	Period: From 09/01/2015 To 08/31/2016	Worksheet D Part IV Date/Time Prepared: 1/25/2017 6:24 pm
	Title XVIII	Subprovider - IPF	PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03950	PRISON CLINIC	0	0	0	0	0	76.02
76.03	03951	WOUNDCARE	0	0	0	0	0	76.03
76.04	03952	OPIC	0	0	0	0	0	76.04
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
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: 150046 | Component CCN: 15S046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part IV | Date/Time Prepared: 1/25/2017 6:24 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	84,231,176	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	11,787,427	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,207,087	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,422,183	0.000000	0.000000	21,821	54.00
54.01	05401	ULTRASOUND	0	3,667,814	0.000000	0.000000	0	54.01
54.02	05402	MAMMOGRAPHY	0	2,415,287	0.000000	0.000000	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	15,862,669	0.000000	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	12,331,906	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	47,309,128	0.000000	0.000000	35,006	57.00
58.00	05800	MRI	0	13,158,459	0.000000	0.000000	17,192	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	21,764,114	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	62,531,829	0.000000	0.000000	489,243	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	6,593,461	0.000000	0.000000	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	18,509,531	0.000000	0.000000	53,065	65.00
66.00	06600	PHYSICAL THERAPY	0	7,131,902	0.000000	0.000000	4,995	66.00
69.00	06900	ELECTROCARDIOLOGY	0	15,306,627	0.000000	0.000000	9,889	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,551,414	0.000000	0.000000	5,541	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	39,517,121	0.000000	0.000000	6,284	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,746,420	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100,305,684	0.000000	0.000000	560,710	73.00
74.00	07400	RENAL DIALYSIS	0	5,530,574	0.000000	0.000000	0	74.00
76.00	03020	LITHOTRIPSY	0	1,284,350	0.000000	0.000000	0	76.00
76.01	03330	ENDOSCOPY	0	7,601,343	0.000000	0.000000	0	76.01
76.02	03950	PRISON CLINIC	0	350,310	0.000000	0.000000	0	76.02
76.03	03951	WOUNDCARE	0	3,331,924	0.000000	0.000000	0	76.03
76.04	03952	OPIC	0	6,162,086	0.000000	0.000000	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	51,794,097	0.000000	0.000000	283,091	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,672,159	0.000000	0.000000	2,586	92.00
200.00		Total (lines 50-199)	0	579,078,082			1,489,423	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150046 | Component CCN: 15S046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part IV | Date/Time Prepared: 1/25/2017 6:24 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	54.01
54.02	05402	MAMMOGRAPHY	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	1,200	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,166	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03020	LITHOTRIPSY	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	76.01
76.02	03950	PRISON CLINIC	0	0	0	76.02
76.03	03951	WOUNDCARE	0	0	0	76.03
76.04	03952	OPIC	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	4,539	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
200.00		Total (lines 50-199)	0	8,905	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150046 | Component CCN: 15S046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part V | Date/Time Prepared: 1/25/2017 6:24 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.086427	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.094024	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.696919	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208779	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.081077	0	0	0	0	54.01
54.02	05402	MAMMOGRAPHY	0.200866	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.113905	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.106475	0	0	0	0	56.00
57.00	05700	CT SCAN	0.026630	0	0	0	0	57.00
58.00	05800	MRI	0.044526	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.056474	0	0	0	0	59.00
60.00	06000	LABORATORY	0.065190	1,200	0	0	78	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.117589	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.111125	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.391754	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.084327	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.112859	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.198140	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.430490	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.119217	3,166	0	3,060	377	73.00
74.00	07400	RENAL DIALYSIS	0.181536	0	0	0	0	74.00
76.00	03020	LITHOTRIPSY	0.155346	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0.125614	0	0	0	0	76.01
76.02	03950	PRISON CLINIC	1.776532	0	0	0	0	76.02
76.03	03951	WOUNDCARE	0.284151	0	0	0	0	76.03
76.04	03952	OPIC	0.163808	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.117835	4,539	0	0	535	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.759950	0	0	0	0	92.00
200.00		Subtotal (see instructions)		8,905	0	3,060	990	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		8,905	0	3,060	990	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150046 | Component CCN: 15S046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part V | Date/Time Prepared: 1/25/2017 6:24 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ULTRASOUND	0	0	54.01
54.02	05402	MAMMOGRAPHY	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	365	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03020	LITHOTRIPSY	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	76.01
76.02	03950	PRISON CLINIC	0	0	76.02
76.03	03951	WOUNDCARE	0	0	76.03
76.04	03952	OPIC	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	365	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	365	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150046 | Component CCN: 15T046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part II | Date/Time Prepared: 1/25/2017 6:24 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	814,387	84,231,176	0.009668	456	4	50.00
51.00	05100	RECOVERY ROOM	70,271	11,787,427	0.005962	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	233,694	3,207,087	0.072868	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	393,051	14,422,183	0.027253	38,375	1,046	54.00
54.01	05401	ULTRASOUND	18,891	3,667,814	0.005150	2,310	12	54.01
54.02	05402	MAMMOGRAPHY	49,524	2,415,287	0.020504	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	197,272	15,862,669	0.012436	0	0	55.00
56.00	05600	RADIOISOTOPE	52,825	12,331,906	0.004284	6,491	28	56.00
57.00	05700	CT SCAN	82,761	47,309,128	0.001749	43,420	76	57.00
58.00	05800	MRI	42,768	13,158,459	0.003250	8,408	27	58.00
59.00	05900	CARDIAC CATHETERIZATION	91,751	21,764,114	0.004216	8,253	35	59.00
60.00	06000	LABORATORY	246,232	62,531,829	0.003938	270,139	1,064	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	28,012	6,593,461	0.004248	27,124	115	62.00
65.00	06500	RESPIRATORY THERAPY	101,056	18,509,531	0.005460	95,245	520	65.00
66.00	06600	PHYSICAL THERAPY	399,239	7,131,902	0.055979	1,672,148	93,605	66.00
69.00	06900	ELECTROCARDIOLOGY	90,893	15,306,627	0.005938	19,982	119	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	30,560	1,551,414	0.019698	5,754	113	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	406,258	39,517,121	0.010281	220,698	2,269	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	197,755	18,746,420	0.010549	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	379,061	100,305,684	0.003779	775,849	2,932	73.00
74.00	07400	RENAL DIALYSIS	36,416	5,530,574	0.006584	159,790	1,052	74.00
76.00	03020	LITHOTRIPSY	5,077	1,284,350	0.003953	0	0	76.00
76.01	03330	ENDOSCOPY	72,629	7,601,343	0.009555	4,545	43	76.01
76.02	03950	PRISON CLINIC	191,635	350,310	0.547044	0	0	76.02
76.03	03951	WOUNDCARE	65,916	3,331,924	0.019783	0	0	76.03
76.04	03952	OPIC	118,713	6,162,086	0.019265	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	459,741	51,794,097	0.008876	3,117	28	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,672,159	0.000000	1,518	0	92.00
200.00		Total (lines 50-199)	4,876,388	579,078,082		3,363,622	103,088	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150046 | Component CCN: 15T046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part IV | Date/Time Prepared: 1/25/2017 6:24 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03950	PRISON CLINIC	0	0	0	0	0	76.02
76.03	03951	WOUNDCARE	0	0	0	0	0	76.03
76.04	03952	OPIC	0	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
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: 150046 | Component CCN: 15T046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part IV | Date/Time Prepared: 1/25/2017 6:24 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	84,231,176	0.000000	0.000000	456	50.00
51.00	05100	RECOVERY ROOM	0	11,787,427	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,207,087	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,422,183	0.000000	0.000000	38,375	54.00
54.01	05401	ULTRASOUND	0	3,667,814	0.000000	0.000000	2,310	54.01
54.02	05402	MAMMOGRAPHY	0	2,415,287	0.000000	0.000000	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	15,862,669	0.000000	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	12,331,906	0.000000	0.000000	6,491	56.00
57.00	05700	CT SCAN	0	47,309,128	0.000000	0.000000	43,420	57.00
58.00	05800	MRI	0	13,158,459	0.000000	0.000000	8,408	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	21,764,114	0.000000	0.000000	8,253	59.00
60.00	06000	LABORATORY	0	62,531,829	0.000000	0.000000	270,139	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	6,593,461	0.000000	0.000000	27,124	62.00
65.00	06500	RESPIRATORY THERAPY	0	18,509,531	0.000000	0.000000	95,245	65.00
66.00	06600	PHYSICAL THERAPY	0	7,131,902	0.000000	0.000000	1,672,148	66.00
69.00	06900	ELECTROCARDIOLOGY	0	15,306,627	0.000000	0.000000	19,982	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,551,414	0.000000	0.000000	5,754	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	39,517,121	0.000000	0.000000	220,698	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,746,420	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100,305,684	0.000000	0.000000	775,849	73.00
74.00	07400	RENAL DIALYSIS	0	5,530,574	0.000000	0.000000	159,790	74.00
76.00	03020	LITHOTRIPSY	0	1,284,350	0.000000	0.000000	0	76.00
76.01	03330	ENDOSCOPY	0	7,601,343	0.000000	0.000000	4,545	76.01
76.02	03950	PRISON CLINIC	0	350,310	0.000000	0.000000	0	76.02
76.03	03951	WOUNDCARE	0	3,331,924	0.000000	0.000000	0	76.03
76.04	03952	OPIC	0	6,162,086	0.000000	0.000000	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	51,794,097	0.000000	0.000000	3,117	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,672,159	0.000000	0.000000	1,518	92.00
200.00		Total (lines 50-199)	0	579,078,082			3,363,622	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150046 | Component CCN: 15T046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part IV | Date/Time Prepared: 1/25/2017 6:24 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	54.01
54.02	05402	MAMMOGRAPHY	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,613	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03020	LITHOTRIPSY	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	76.01
76.02	03950	PRISON CLINIC	0	0	0	76.02
76.03	03951	WOUNDCARE	0	0	0	76.03
76.04	03952	OPIC	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
200.00		Total (lines 50-199)	0	1,613	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150046 | Component CCN: 15T046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part V | Date/Time Prepared: 1/25/2017 6:24 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.086427	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.094024	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.696919	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208779	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.081077	0	0	0	0	54.01
54.02	05402	MAMMOGRAPHY	0.200866	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.113905	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.106475	0	0	0	0	56.00
57.00	05700	CT SCAN	0.026630	0	0	0	0	57.00
58.00	05800	MRI	0.044526	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.056474	0	0	0	0	59.00
60.00	06000	LABORATORY	0.065190	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.117589	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.111125	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.391754	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.084327	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.112859	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.198140	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.430490	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.119217	1,613	0	1,994	192	73.00
74.00	07400	RENAL DIALYSIS	0.181536	0	0	0	0	74.00
76.00	03020	LITHOTRIPSY	0.155346	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0.125614	0	0	0	0	76.01
76.02	03950	PRISON CLINIC	1.776532	0	0	0	0	76.02
76.03	03951	WOUNDCARE	0.284151	0	0	0	0	76.03
76.04	03952	OPIC	0.163808	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.117835	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.759950	0	0	0	0	92.00
200.00		Subtotal (see instructions)		1,613	0	1,994	192	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		1,613	0	1,994	192	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150046 | Component CCN: 15T046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part V | Date/Time Prepared: 1/25/2017 6:24 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ULTRASOUND	0	0	54.01
54.02	05402	MAMMOGRAPHY	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	238	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03020	LITHOTRIPSY	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	76.01
76.02	03950	PRISON CLINIC	0	0	76.02
76.03	03951	WOUNDCARE	0	0	76.03
76.04	03952	OPIC	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	238	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	238	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 150046	Period: From 09/01/2015 To 08/31/2016	Worksheet D Part I Date/Time Prepared: 1/25/2017 6:24 pm
	Title XIX	Hospital	Cost

	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	2,060,531	0	2,060,531	21,871	94.21	30.00
31.00	INTENSIVE CARE UNIT	391,029		391,029	3,365	116.20	31.00
40.00	SUBPROVIDER - IPF	389,315	0	389,315	6,404	60.79	40.00
41.00	SUBPROVIDER - IRF	335,277	0	335,277	1,827	183.51	41.00
43.00	NURSERY	36,429		36,429	563	64.71	43.00
200.00	Total (lines 30-199)	3,212,581		3,212,581	34,030		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	1,179	111,074	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
40.00	SUBPROVIDER - IPF	2,903	176,473	40.00
41.00	SUBPROVIDER - IRF	95	17,433	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	4,177	304,980	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part II | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	814,387	84,231,176	0.009668	7,022,337	67,892	50.00
51.00	05100	RECOVERY ROOM	70,271	11,787,427	0.005962	796,473	4,749	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	233,694	3,207,087	0.072868	1,622,822	118,252	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	393,051	14,422,183	0.027253	692,464	18,872	54.00
54.01	05401	ULTRASOUND	18,891	3,667,814	0.005150	183,370	944	54.01
54.02	05402	MAMMOGRAPHY	49,524	2,415,287	0.020504	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	197,272	15,862,669	0.012436	154,070	1,916	55.00
56.00	05600	RADIOISOTOPE	52,825	12,331,906	0.004284	128,941	552	56.00
57.00	05700	CT SCAN	82,761	47,309,128	0.001749	2,662,596	4,657	57.00
58.00	05800	MRI	42,768	13,158,459	0.003250	649,502	2,111	58.00
59.00	05900	CARDIAC CATHETERIZATION	91,751	21,764,114	0.004216	1,513,192	6,380	59.00
60.00	06000	LABORATORY	246,232	62,531,829	0.003938	4,309,576	16,971	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	28,012	6,593,461	0.004248	842,536	3,579	62.00
65.00	06500	RESPIRATORY THERAPY	101,056	18,509,531	0.005460	3,005,323	16,409	65.00
66.00	06600	PHYSICAL THERAPY	399,239	7,131,902	0.055979	267,187	14,957	66.00
69.00	06900	ELECTROCARDIOLOGY	90,893	15,306,627	0.005938	1,006,459	5,976	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	30,560	1,551,414	0.019698	108,691	2,141	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	406,258	39,517,121	0.010281	2,966,913	30,503	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	197,755	18,746,420	0.010549	1,691,968	17,849	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	379,061	100,305,684	0.003779	10,065,452	38,037	73.00
74.00	07400	RENAL DIALYSIS	36,416	5,530,574	0.006584	651,842	4,292	74.00
76.00	03020	LITHOTRIPSY	5,077	1,284,350	0.003953	0	0	76.00
76.01	03330	ENDOSCOPY	72,629	7,601,343	0.009555	302,713	2,892	76.01
76.02	03950	PRISON CLINIC	191,635	350,310	0.547044	1,236	676	76.02
76.03	03951	WOUNDCARE	65,916	3,331,924	0.019783	10,939	216	76.03
76.04	03952	OPIC	118,713	6,162,086	0.019265	7,411	143	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	459,741	51,794,097	0.008876	2,326,007	20,646	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	243,916	2,672,159	0.091280	0	0	92.00
200.00		Total (lines 50-199)	5,120,304	579,078,082		42,990,020	401,612	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150046	Period: From 09/01/2015 To 08/31/2016	Worksheet D Part III Date/Time Prepared: 1/25/2017 6:24 pm
	Title XIX	Hospital	Cost

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			6.00	7.00	8.00	9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	21,871	0.00	1,179	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,365	0.00	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	6,404	0.00	2,903	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,827	0.00	95	0	41.00
43.00	04300	NURSERY	563	0.00	0	0	43.00
200.00		Total (lines 30-199)	34,030		4,177	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part IV | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03950	PRISON CLINIC	0	0	0	0	0	76.02
76.03	03951	WOUNDCARE	0	0	0	0	0	76.03
76.04	03952	OPIC	0	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
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: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part IV | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	84,231,176	0.000000	0.000000	7,022,337	50.00
51.00	05100	RECOVERY ROOM	0	11,787,427	0.000000	0.000000	796,473	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,207,087	0.000000	0.000000	1,622,822	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,422,183	0.000000	0.000000	692,464	54.00
54.01	05401	ULTRASOUND	0	3,667,814	0.000000	0.000000	183,370	54.01
54.02	05402	MAMMOGRAPHY	0	2,415,287	0.000000	0.000000	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	15,862,669	0.000000	0.000000	154,070	55.00
56.00	05600	RADIOISOTOPE	0	12,331,906	0.000000	0.000000	128,941	56.00
57.00	05700	CT SCAN	0	47,309,128	0.000000	0.000000	2,662,596	57.00
58.00	05800	MRI	0	13,158,459	0.000000	0.000000	649,502	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	21,764,114	0.000000	0.000000	1,513,192	59.00
60.00	06000	LABORATORY	0	62,531,829	0.000000	0.000000	4,309,576	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	6,593,461	0.000000	0.000000	842,536	62.00
65.00	06500	RESPIRATORY THERAPY	0	18,509,531	0.000000	0.000000	3,005,323	65.00
66.00	06600	PHYSICAL THERAPY	0	7,131,902	0.000000	0.000000	267,187	66.00
69.00	06900	ELECTROCARDIOLOGY	0	15,306,627	0.000000	0.000000	1,006,459	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,551,414	0.000000	0.000000	108,691	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	39,517,121	0.000000	0.000000	2,966,913	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,746,420	0.000000	0.000000	1,691,968	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100,305,684	0.000000	0.000000	10,065,452	73.00
74.00	07400	RENAL DIALYSIS	0	5,530,574	0.000000	0.000000	651,842	74.00
76.00	03020	LITHOTRIPSY	0	1,284,350	0.000000	0.000000	0	76.00
76.01	03330	ENDOSCOPY	0	7,601,343	0.000000	0.000000	302,713	76.01
76.02	03950	PRISON CLINIC	0	350,310	0.000000	0.000000	1,236	76.02
76.03	03951	WOUNDCARE	0	3,331,924	0.000000	0.000000	10,939	76.03
76.04	03952	OPIC	0	6,162,086	0.000000	0.000000	7,411	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	51,794,097	0.000000	0.000000	2,326,007	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,672,159	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	579,078,082			42,990,020	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part IV | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	54.01
54.02	05402	MAMMOGRAPHY	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03020	LITHOTRIPSY	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	76.01
76.02	03950	PRISON CLINIC	0	0	0	76.02
76.03	03951	WOUNDCARE	0	0	0	76.03
76.04	03952	OPIC	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part V Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.086427	0	0	10,232,445	0	50.00
51.00	05100	RECOVERY ROOM	0.094024	0	0	1,894,553	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.696919	0	0	25,448	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208779	0	0	2,716,526	0	54.00
54.01	05401	ULTRASOUND	0.081077	0	0	661,516	0	54.01
54.02	05402	MAMMOGRAPHY	0.200866	0	0	194,477	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.113905	0	0	1,039,721	0	55.00
56.00	05600	RADIOISOTOPE	0.106475	0	0	1,206,421	0	56.00
57.00	05700	CT SCAN	0.026630	0	0	7,083,974	0	57.00
58.00	05800	MRI	0.044526	0	0	1,538,404	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.056474	0	0	1,062,386	0	59.00
60.00	06000	LABORATORY	0.065190	0	0	8,724,862	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.117589	0	0	195,089	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.111125	0	0	419,051	0	65.00
66.00	06600	PHYSICAL THERAPY	0.391754	0	0	454,259	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.084327	0	0	1,446,941	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.112859	0	0	315,195	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.198140	0	0	3,248,054	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.430490	0	0	1,737,451	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.119217	0	0	6,551,167	0	73.00
74.00	07400	RENAL DIALYSIS	0.181536	0	0	4,227	0	74.00
76.00	03020	LITHOTRIPSY	0.155346	0	0	240,017	0	76.00
76.01	03330	ENDOSCOPY	0.125614	0	0	620,855	0	76.01
76.02	03950	PRISON CLINIC	1.776532	0	0	0	0	76.02
76.03	03951	WOUNDCARE	0.284151	0	0	343,177	0	76.03
76.04	03952	OPIC	0.163808	0	0	376,928	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.117835	0	0	12,899,548	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.759950	0	0	765,822	0	92.00
200.00		Subtotal (see instructions)		0	0	65,998,514	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	65,998,514	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part V Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	884,360	50.00
51.00	05100	RECOVERY ROOM	0	178,133	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,735	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	567,154	54.00
54.01	05401	ULTRASOUND	0	53,634	54.01
54.02	05402	MAMMOGRAPHY	0	39,064	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	118,429	55.00
56.00	05600	RADIOISOTOPE	0	128,454	56.00
57.00	05700	CT SCAN	0	188,646	57.00
58.00	05800	MRI	0	68,499	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59,997	59.00
60.00	06000	LABORATORY	0	568,774	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	22,940	62.00
65.00	06500	RESPIRATORY THERAPY	0	46,567	65.00
66.00	06600	PHYSICAL THERAPY	0	177,958	66.00
69.00	06900	ELECTROCARDIOLOGY	0	122,016	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	35,573	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	643,569	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	747,955	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	781,010	73.00
74.00	07400	RENAL DIALYSIS	0	767	74.00
76.00	03020	LITHOTRIPSY	0	37,286	76.00
76.01	03330	ENDOSCOPY	0	77,988	76.01
76.02	03950	PRISON CLINIC	0	0	76.02
76.03	03951	WOUNDCARE	0	97,514	76.03
76.04	03952	OPIC	0	61,744	76.04
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	1,520,018	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	581,986	92.00
200.00		Subtotal (see instructions)	0	7,827,770	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	7,827,770	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150046 | Component CCN: 15S046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part II | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	814,387	84,231,176	0.009668	2,430	23	50.00
51.00	05100	RECOVERY ROOM	70,271	11,787,427	0.005962	2,123	13	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	233,694	3,207,087	0.072868	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	393,051	14,422,183	0.027253	35,453	966	54.00
54.01	05401	ULTRASOUND	18,891	3,667,814	0.005150	13,396	69	54.01
54.02	05402	MAMMOGRAPHY	49,524	2,415,287	0.020504	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	197,272	15,862,669	0.012436	0	0	55.00
56.00	05600	RADIOISOTOPE	52,825	12,331,906	0.004284	0	0	56.00
57.00	05700	CT SCAN	82,761	47,309,128	0.001749	129,084	226	57.00
58.00	05800	MRI	42,768	13,158,459	0.003250	8,408	27	58.00
59.00	05900	CARDIAC CATHETERIZATION	91,751	21,764,114	0.004216	0	0	59.00
60.00	06000	LABORATORY	246,232	62,531,829	0.003938	1,274,782	5,020	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	28,012	6,593,461	0.004248	1,678	7	62.00
65.00	06500	RESPIRATORY THERAPY	101,056	18,509,531	0.005460	41,437	226	65.00
66.00	06600	PHYSICAL THERAPY	399,239	7,131,902	0.055979	3,933	220	66.00
69.00	06900	ELECTROCARDIOLOGY	90,893	15,306,627	0.005938	38,466	228	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	30,560	1,551,414	0.019698	5,541	109	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	406,258	39,517,121	0.010281	16,785	173	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	197,755	18,746,420	0.010549	1,064,479	11,229	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	379,061	100,305,684	0.003779	0	0	73.00
74.00	07400	RENAL DIALYSIS	36,416	5,530,574	0.006584	0	0	74.00
76.00	03020	LITHOTRIPSY	5,077	1,284,350	0.003953	0	0	76.00
76.01	03330	ENDOSCOPY	72,629	7,601,343	0.009555	4,545	43	76.01
76.02	03950	PRISON CLINIC	191,635	350,310	0.547044	0	0	76.02
76.03	03951	WOUNDCARE	65,916	3,331,924	0.019783	0	0	76.03
76.04	03952	OPIC	118,713	6,162,086	0.019265	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	459,741	51,794,097	0.008876	796,530	7,070	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,672,159	0.000000	9,917	0	92.00
200.00		Total (lines 50-199)	4,876,388	579,078,082		3,448,987	25,649	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150046 | Component CCN: 15S046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part IV | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03950	PRISON CLINIC	0	0	0	0	0	76.02
76.03	03951	WOUNDCARE	0	0	0	0	0	76.03
76.04	03952	OPIC	0	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
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: 150046 | Component CCN: 15S046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part IV | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	84,231,176	0.000000	0.000000	2,430	50.00
51.00	05100	RECOVERY ROOM	0	11,787,427	0.000000	0.000000	2,123	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,207,087	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,422,183	0.000000	0.000000	35,453	54.00
54.01	05401	ULTRASOUND	0	3,667,814	0.000000	0.000000	13,396	54.01
54.02	05402	MAMMOGRAPHY	0	2,415,287	0.000000	0.000000	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	15,862,669	0.000000	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	12,331,906	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	47,309,128	0.000000	0.000000	129,084	57.00
58.00	05800	MRI	0	13,158,459	0.000000	0.000000	8,408	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	21,764,114	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	62,531,829	0.000000	0.000000	1,274,782	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	6,593,461	0.000000	0.000000	1,678	62.00
65.00	06500	RESPIRATORY THERAPY	0	18,509,531	0.000000	0.000000	41,437	65.00
66.00	06600	PHYSICAL THERAPY	0	7,131,902	0.000000	0.000000	3,933	66.00
69.00	06900	ELECTROCARDIOLOGY	0	15,306,627	0.000000	0.000000	38,466	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,551,414	0.000000	0.000000	5,541	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	39,517,121	0.000000	0.000000	16,785	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,746,420	0.000000	0.000000	1,064,479	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100,305,684	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	5,530,574	0.000000	0.000000	0	74.00
76.00	03020	LITHOTRIPSY	0	1,284,350	0.000000	0.000000	0	76.00
76.01	03330	ENDOSCOPY	0	7,601,343	0.000000	0.000000	4,545	76.01
76.02	03950	PRISON CLINIC	0	350,310	0.000000	0.000000	0	76.02
76.03	03951	WOUNDCARE	0	3,331,924	0.000000	0.000000	0	76.03
76.04	03952	OPIC	0	6,162,086	0.000000	0.000000	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	51,794,097	0.000000	0.000000	796,530	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,672,159	0.000000	0.000000	9,917	92.00
200.00		Total (lines 50-199)	0	579,078,082			3,448,987	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150046 Component CCN: 15S046	Period: From 09/01/2015 To 08/31/2016	Worksheet D Part IV Date/Time Prepared: 1/25/2017 6:24 pm
	Title XIX	Subprovider - IPF	Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	54.01
54.02	05402	MAMMOGRAPHY	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03020	LITHOTRIPSY	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	76.01
76.02	03950	PRISON CLINIC	0	0	0	76.02
76.03	03951	WOUNDCARE	0	0	0	76.03
76.04	03952	OPIC	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150046 | Component CCN: 15T046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part II | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	814,387	84,231,176	0.009668	0	0	50.00
51.00	05100	RECOVERY ROOM	70,271	11,787,427	0.005962	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	233,694	3,207,087	0.072868	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	393,051	14,422,183	0.027253	10,066	274	54.00
54.01	05401	ULTRASOUND	18,891	3,667,814	0.005150	1,218	6	54.01
54.02	05402	MAMMOGRAPHY	49,524	2,415,287	0.020504	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	197,272	15,862,669	0.012436	0	0	55.00
56.00	05600	RADIOISOTOPE	52,825	12,331,906	0.004284	0	0	56.00
57.00	05700	CT SCAN	82,761	47,309,128	0.001749	9,041	16	57.00
58.00	05800	MRI	42,768	13,158,459	0.003250	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	91,751	21,764,114	0.004216	0	0	59.00
60.00	06000	LABORATORY	246,232	62,531,829	0.003938	58,817	232	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	28,012	6,593,461	0.004248	10,966	47	62.00
65.00	06500	RESPIRATORY THERAPY	101,056	18,509,531	0.005460	63,731	348	65.00
66.00	06600	PHYSICAL THERAPY	399,239	7,131,902	0.055979	460,176	25,760	66.00
69.00	06900	ELECTROCARDIOLOGY	90,893	15,306,627	0.005938	7,232	43	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	30,560	1,551,414	0.019698	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	406,258	39,517,121	0.010281	17,567	181	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	197,755	18,746,420	0.010549	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	379,061	100,305,684	0.003779	292,469	1,105	73.00
74.00	07400	RENAL DIALYSIS	36,416	5,530,574	0.006584	22,827	150	74.00
76.00	03020	LITHOTRIPSY	5,077	1,284,350	0.003953	0	0	76.00
76.01	03330	ENDOSCOPY	72,629	7,601,343	0.009555	0	0	76.01
76.02	03950	PRISON CLINIC	191,635	350,310	0.547044	0	0	76.02
76.03	03951	WOUNDCARE	65,916	3,331,924	0.019783	0	0	76.03
76.04	03952	OPIC	118,713	6,162,086	0.019265	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	459,741	51,794,097	0.008876	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,672,159	0.000000	0	0	92.00
200.00		Total (lines 50-199)	4,876,388	579,078,082		954,110	28,162	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150046 | Component CCN: 15T046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part IV | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	05402	MAMMOGRAPHY	0	0	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	0	0	76.01
76.02	03950	PRISON CLINIC	0	0	0	0	0	76.02
76.03	03951	WOUNDCARE	0	0	0	0	0	76.03
76.04	03952	OPIC	0	0	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
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: 150046 | Component CCN: 15T046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part IV | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	84,231,176	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	11,787,427	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,207,087	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,422,183	0.000000	0.000000	10,066	54.00
54.01	05401	ULTRASOUND	0	3,667,814	0.000000	0.000000	1,218	54.01
54.02	05402	MAMMOGRAPHY	0	2,415,287	0.000000	0.000000	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	15,862,669	0.000000	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	12,331,906	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	47,309,128	0.000000	0.000000	9,041	57.00
58.00	05800	MRI	0	13,158,459	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	21,764,114	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	62,531,829	0.000000	0.000000	58,817	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	6,593,461	0.000000	0.000000	10,966	62.00
65.00	06500	RESPIRATORY THERAPY	0	18,509,531	0.000000	0.000000	63,731	65.00
66.00	06600	PHYSICAL THERAPY	0	7,131,902	0.000000	0.000000	460,176	66.00
69.00	06900	ELECTROCARDIOLOGY	0	15,306,627	0.000000	0.000000	7,232	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,551,414	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	39,517,121	0.000000	0.000000	17,567	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,746,420	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100,305,684	0.000000	0.000000	292,469	73.00
74.00	07400	RENAL DIALYSIS	0	5,530,574	0.000000	0.000000	22,827	74.00
76.00	03020	LITHOTRIPSY	0	1,284,350	0.000000	0.000000	0	76.00
76.01	03330	ENDOSCOPY	0	7,601,343	0.000000	0.000000	0	76.01
76.02	03950	PRISON CLINIC	0	350,310	0.000000	0.000000	0	76.02
76.03	03951	WOUNDCARE	0	3,331,924	0.000000	0.000000	0	76.03
76.04	03952	OPIC	0	6,162,086	0.000000	0.000000	0	76.04
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	51,794,097	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,672,159	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	579,078,082			954,110	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150046 | Component CCN: 15T046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D Part IV | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	54.01
54.02	05402	MAMMOGRAPHY	0	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03020	LITHOTRIPSY	0	0	0	76.00
76.01	03330	ENDOSCOPY	0	0	0	76.01
76.02	03950	PRISON CLINIC	0	0	0	76.02
76.03	03951	WOUNDCARE	0	0	0	76.03
76.04	03952	OPIC	0	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D-1 | Date/Time Prepared: 1/25/2017 6:24 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	21,871	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	21,871	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)	19,282	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)	10,985	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	17,154,791	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)	17,154,791	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	17,154,791	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	784.36	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	8,616,195	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)	8,616,195	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D-1 | Date/Time Prepared: 1/25/2017 6:24 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,503,084	3,365	1,338.21	1,767	2,364,617	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)	17,034,280	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	28,015,092	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,240,222	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	994,932	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,235,154	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	25,779,938	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,589	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	784.36	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,030,708	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D-1 | Date/Time Prepared: 1/25/2017 6:24 pm

Title XVIII | Hospital | PPS

	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	2,060,531	17,154,791	0.120114	2,030,708	243,916	90.00
91.00	Nursing School cost	0	17,154,791	0.000000	2,030,708	0	91.00
92.00	Allied health cost	0	17,154,791	0.000000	2,030,708	0	92.00
93.00	All other Medical Education	0	17,154,791	0.000000	2,030,708	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150046 | Component CCN: 15S046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D-1 | Date/Time Prepared: 1/25/2017 6:24 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,404	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,404	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)	6,404	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,426	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,387,554	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)	4,387,554	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,387,554	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	685.13	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	976,995	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)	976,995	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150046 | Component CCN: 15S046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D-1 | Date/Time Prepared: 1/25/2017 6:24 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	151,081	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,128,076	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)	86,687	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	8,074	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	94,761	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,033,315	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: 150046 Component CCN: 15S046	Period: From 09/01/2015 To 08/31/2016	Worksheet D-1 Date/Time Prepared: 1/25/2017 6:24 pm
	Title XVIII	Subprovider - IPF	PPS

	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	389,315	4,387,554	0.088732	0	0	90.00
91.00	Nursing School cost	0	4,387,554	0.000000	0	0	91.00
92.00	Allied health cost	0	4,387,554	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,387,554	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150046 | Component CCN: 15T046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D-1 | Date/Time Prepared: 1/25/2017 6:24 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,827	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,827	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)	1,827	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,143	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,137,565	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)	2,137,565	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,137,565	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,169.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,337,299	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,337,299	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150046 | Component CCN: 15T046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D-1 | Date/Time Prepared: 1/25/2017 6:24 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	871,606	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,208,905	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)	209,752	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	103,088	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	312,840	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,896,065	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: 150046 Component CCN: 15T046	Period: From 09/01/2015 To 08/31/2016	Worksheet D-1 Date/Time Prepared: 1/25/2017 6:24 pm
	Title XVIII	Subprovider - IRF	PPS

	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	335,277	2,137,565	0.156850	0	0	90.00
91.00	Nursing School cost	0	2,137,565	0.000000	0	0	91.00
92.00	Allied health cost	0	2,137,565	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,137,565	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D-1 | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	21,871	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	21,871	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)	19,282	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,179	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)	563	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	17,131,414	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)	17,131,414	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	17,131,414	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	783.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	923,499	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)	923,499	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D-1 | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	416,222	563	739.29	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,503,084	3,365	1,338.21	0	0	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)	6,057,746	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,981,245	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,589	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	783.29	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,027,938	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D-1 | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Hospital | Cost

	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	2,060,531	17,131,414	0.120278	2,027,938	243,916	90.00
91.00	Nursing School cost	0	17,131,414	0.000000	2,027,938	0	91.00
92.00	Allied health cost	0	17,131,414	0.000000	2,027,938	0	92.00
93.00	All other Medical Education	0	17,131,414	0.000000	2,027,938	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D-1
Component CCN: 15S046 | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Subprovider - IPF | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,404	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,404	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)	6,404	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)	2,903	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)	563	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,387,554	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)	4,387,554	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,387,554	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	685.13	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,988,932	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,988,932	41.00

COMPUTATION OF INPATIENT OPERATING COST

	Provider CCN: 150046 Component CCN: 15S046	Period: From 09/01/2015 To 08/31/2016	Worksheet D-1 Date/Time Prepared: 1/25/2017 6:24 pm
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	669,565	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,658,497	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150046 Component CCN: 15S046	Period: From 09/01/2015 To 08/31/2016	Worksheet D-1 Date/Time Prepared: 1/25/2017 6:24 pm
	Title XIX	Subprovider - IPF	Cost

	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	389,315	4,387,554	0.088732	0	0	90.00
91.00	Nursing School cost	0	4,387,554	0.000000	0	0	91.00
92.00	Allied health cost	0	4,387,554	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,387,554	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150046 | Component CCN: 15T046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D-1 | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,827	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,827	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)	1,827	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)	95	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)	563	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,137,565	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)	2,137,565	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,137,565	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,169.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	111,149	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)	111,149	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D-1
Component CCN: 15T046 | | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	238,025	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	349,174	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D-1

Component CCN: 15T046 | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Subprovider - IRF | Cost

	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	335,277	2,137,565	0.156850	0	0	90.00
91.00	Nursing School cost	0	2,137,565	0.000000	0	0	91.00
92.00	Allied health cost	0	2,137,565	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,137,565	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D-3 | Date/Time Prepared: 1/25/2017 6:24 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		10,321,037		30.00
31.00	03100	INTENSIVE CARE UNIT		4,718,532		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.086468	18,083,696	1,563,661	50.00
51.00	05100	RECOVERY ROOM	0.094024	1,965,163	184,772	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.696919	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208779	2,440,979	509,625	54.00
54.01	05401	ULTRASOUND	0.081077	426,727	34,598	54.01
54.02	05402	MAMMOGRAPHY	0.200866	3,268	656	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.113905	553,752	63,075	55.00
56.00	05600	RADIOISOTOPE	0.106475	670,480	71,389	56.00
57.00	05700	CT SCAN	0.026630	7,766,827	206,831	57.00
58.00	05800	MRI	0.044526	1,810,333	80,607	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.056474	6,427,905	363,010	59.00
60.00	06000	LABORATORY	0.065190	15,271,598	995,555	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.117589	2,784,324	327,406	62.00
65.00	06500	RESPIRATORY THERAPY	0.111125	10,355,163	1,150,717	65.00
66.00	06600	PHYSICAL THERAPY	0.394477	1,483,582	585,239	66.00
69.00	06900	ELECTROCARDIOLOGY	0.085079	4,831,728	411,079	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.112859	383,246	43,253	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.198140	12,471,728	2,471,148	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.430490	5,672,198	2,441,825	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.119217	30,595,601	3,647,516	73.00
74.00	07400	RENAL DIALYSIS	0.181536	3,241,604	588,468	74.00
76.00	03020	LITHOTRIPSY	0.155346	0	0	76.00
76.01	03330	ENDOSCOPY	0.125614	1,254,111	157,534	76.01
76.02	03950	PRISON CLINIC	1.776532	0	0	76.02
76.03	03951	WOUNDCARE	0.286761	40,595	11,641	76.03
76.04	03952	OPIC	0.170370	54,645	9,310	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.118496	6,973,980	826,389	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.759950	380,256	288,976	92.00
200.00		Total (sum of lines 50-94 and 96-98)		135,943,489	17,034,280	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)		135,943,489		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D-3
Component CCN: 15S046 | Date/Time Prepared: 1/25/2017 6:24 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		4,939,478		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.086468	0	0	50.00
51.00	05100	RECOVERY ROOM	0.094024	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.696919	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208779	21,821	4,556	54.00
54.01	05401	ULTRASOUND	0.081077	0	0	54.01
54.02	05402	MAMMOGRAPHY	0.200866	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.113905	0	0	55.00
56.00	05600	RADIOISOTOPE	0.106475	0	0	56.00
57.00	05700	CT SCAN	0.026630	35,006	932	57.00
58.00	05800	MRI	0.044526	17,192	765	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.056474	0	0	59.00
60.00	06000	LABORATORY	0.065190	489,243	31,894	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.117589	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.111125	53,065	5,897	65.00
66.00	06600	PHYSICAL THERAPY	0.394477	4,995	1,970	66.00
69.00	06900	ELECTROCARDIOLOGY	0.085079	9,889	841	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.112859	5,541	625	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.198140	6,284	1,245	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.430490	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.119217	560,710	66,846	73.00
74.00	07400	RENAL DIALYSIS	0.181536	0	0	74.00
76.00	03020	LITHOTRIPSY	0.155346	0	0	76.00
76.01	03330	ENDOSCOPY	0.125614	0	0	76.01
76.02	03950	PRISON CLINIC	1.776532	0	0	76.02
76.03	03951	WOUNDCARE	0.286761	0	0	76.03
76.04	03952	OPIC	0.170370	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.118496	283,091	33,545	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.759950	2,586	1,965	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,489,423	151,081	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)		1,489,423		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 150046	Period: From 09/01/2015	Worksheet D-3
	Component CCN: 15T046	To 08/31/2016	Date/Time Prepared: 1/25/2017 6:24 pm
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		1,361,113		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.086468	456	39	50.00
51.00	05100	RECOVERY ROOM	0.094024	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.696919	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208779	38,375	8,012	54.00
54.01	05401	ULTRASOUND	0.081077	2,310	187	54.01
54.02	05402	MAMMOGRAPHY	0.200866	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.113905	0	0	55.00
56.00	05600	RADIOISOTOPE	0.106475	6,491	691	56.00
57.00	05700	CT SCAN	0.026630	43,420	1,156	57.00
58.00	05800	MRI	0.044526	8,408	374	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.056474	8,253	466	59.00
60.00	06000	LABORATORY	0.065190	270,139	17,610	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.117589	27,124	3,189	62.00
65.00	06500	RESPIRATORY THERAPY	0.111125	95,245	10,584	65.00
66.00	06600	PHYSICAL THERAPY	0.394477	1,672,148	659,624	66.00
69.00	06900	ELECTROCARDIOLOGY	0.085079	19,982	1,700	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.112859	5,754	649	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.198140	220,698	43,729	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.430490	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.119217	775,849	92,494	73.00
74.00	07400	RENAL DIALYSIS	0.181536	159,790	29,008	74.00
76.00	03020	LITHOTRIPSY	0.155346	0	0	76.00
76.01	03330	ENDOSCOPY	0.125614	4,545	571	76.01
76.02	03950	PRISON CLINIC	1.776532	0	0	76.02
76.03	03951	WOUNDCARE	0.286761	0	0	76.03
76.04	03952	OPIC	0.170370	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.118496	3,117	369	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.759950	1,518	1,154	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,363,622	871,606	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)		3,363,622		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D-3 | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Hospital | Cost

		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		3,413,183		30.00
31.00	03100	INTENSIVE CARE UNIT		1,456,857		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		500,687		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.086427	7,022,337	606,920	50.00
51.00	05100	RECOVERY ROOM	0.094024	796,473	74,888	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.696919	1,622,822	1,130,975	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208779	692,464	144,572	54.00
54.01	05401	ULTRASOUND	0.081077	183,370	14,867	54.01
54.02	05402	MAMMOGRAPHY	0.200866	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.113905	154,070	17,549	55.00
56.00	05600	RADIOISOTOPE	0.106475	128,941	13,729	56.00
57.00	05700	CT SCAN	0.026630	2,662,596	70,905	57.00
58.00	05800	MRI	0.044526	649,502	28,920	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.056474	1,513,192	85,456	59.00
60.00	06000	LABORATORY	0.065190	4,309,576	280,941	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.117589	842,536	99,073	62.00
65.00	06500	RESPIRATORY THERAPY	0.111125	3,005,323	333,967	65.00
66.00	06600	PHYSICAL THERAPY	0.391754	267,187	104,672	66.00
69.00	06900	ELECTROCARDIOLOGY	0.084327	1,006,459	84,872	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.112859	108,691	12,267	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.198140	2,966,913	587,864	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.430490	1,691,968	728,375	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.119217	10,065,452	1,199,973	73.00
74.00	07400	RENAL DIALYSIS	0.181536	651,842	118,333	74.00
76.00	03020	LITHOTRIPSY	0.155346	0	0	76.00
76.01	03330	ENDOSCOPY	0.125614	302,713	38,025	76.01
76.02	03950	PRISON CLINIC	1.776532	1,236	2,196	76.02
76.03	03951	WOUNDCARE	0.284151	10,939	3,108	76.03
76.04	03952	OPIC	0.163808	7,411	1,214	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.117835	2,326,007	274,085	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.759950	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		42,990,020	6,057,746	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)		42,990,020		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150046 | Component CCN: 15S046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D-3 | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		10,192,851		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.086427	2,430	210	50.00
51.00	05100	RECOVERY ROOM	0.094024	2,123	200	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.696919	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208779	35,453	7,402	54.00
54.01	05401	ULTRASOUND	0.081077	13,396	1,086	54.01
54.02	05402	MAMMOGRAPHY	0.200866	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.113905	0	0	55.00
56.00	05600	RADIOISOTOPE	0.106475	0	0	56.00
57.00	05700	CT SCAN	0.026630	129,084	3,438	57.00
58.00	05800	MRI	0.044526	8,408	374	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.056474	0	0	59.00
60.00	06000	LABORATORY	0.065190	1,274,782	83,103	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.117589	1,678	197	62.00
65.00	06500	RESPIRATORY THERAPY	0.111125	41,437	4,605	65.00
66.00	06600	PHYSICAL THERAPY	0.391754	3,933	1,541	66.00
69.00	06900	ELECTROCARDIOLOGY	0.084327	38,466	3,244	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.112859	5,541	625	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.198140	16,785	3,326	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.430490	1,064,479	458,248	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.119217	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.181536	0	0	74.00
76.00	03020	LITHOTRIPSY	0.155346	0	0	76.00
76.01	03330	ENDOSCOPY	0.125614	4,545	571	76.01
76.02	03950	PRISON CLINIC	1.776532	0	0	76.02
76.03	03951	WOUNDCARE	0.284151	0	0	76.03
76.04	03952	OPIC	0.163808	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.117835	796,530	93,859	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.759950	9,917	7,536	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,448,987	669,565	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)		3,448,987		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150046 | Component CCN: 15T046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet D-3 | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		379,626		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.086427	0	0	50.00
51.00	05100	RECOVERY ROOM	0.094024	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.696919	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208779	10,066	2,102	54.00
54.01	05401	ULTRASOUND	0.081077	1,218	99	54.01
54.02	05402	MAMMOGRAPHY	0.200866	0	0	54.02
55.00	05500	RADIOLOGY-THERAPEUTIC	0.113905	0	0	55.00
56.00	05600	RADIOISOTOPE	0.106475	0	0	56.00
57.00	05700	CT SCAN	0.026630	9,041	241	57.00
58.00	05800	MRI	0.044526	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.056474	0	0	59.00
60.00	06000	LABORATORY	0.065190	58,817	3,834	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.117589	10,966	1,289	62.00
65.00	06500	RESPIRATORY THERAPY	0.111125	63,731	7,082	65.00
66.00	06600	PHYSICAL THERAPY	0.391754	460,176	180,276	66.00
69.00	06900	ELECTROCARDIOLOGY	0.084327	7,232	610	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.112859	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.198140	17,567	3,481	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.430490	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.119217	292,469	34,867	73.00
74.00	07400	RENAL DIALYSIS	0.181536	22,827	4,144	74.00
76.00	03020	LITHOTRIPSY	0.155346	0	0	76.00
76.01	03330	ENDOSCOPY	0.125614	0	0	76.01
76.02	03950	PRISON CLINIC	1.776532	0	0	76.02
76.03	03951	WOUNDCARE	0.284151	0	0	76.03
76.04	03952	OPIC	0.163808	0	0	76.04
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.117835	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.759950	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		954,110	238,025	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)		954,110		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet E Part A Date/Time Prepared: 1/25/2017 6:24 pm

Title XVIII | Hospital | PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,609,704	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	19,913,973	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	810,031	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	152.71	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5.68	30.00
31.00	Percentage of Medicaid patient days (see instructions)	18.53	31.00
32.00	Sum of lines 30 and 31	24.21	32.00
33.00	Allowable disproportionate share percentage (see instructions)	9.19	33.00
34.00	Disproportionate share adjustment (see instructions)	494,507	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150046	Period: From 09/01/2015 To 08/31/2016	Worksheet E Part A Date/Time Prepared: 1/25/2017 6:24 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000115775	0.000114159	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	885,405	731,318	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	72,773	671,374	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	744,147		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	23,572,362		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	23,572,362	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,897,100	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	6,192	54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	25,475,654	59.00
60.00	Primary payer payments	10,966	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	25,464,688	61.00
62.00	Deductibles billed to program beneficiaries	2,346,932	62.00
63.00	Coinsurance billed to program beneficiaries	70,287	63.00
64.00	Allowable bad debts (see instructions)	220,202	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	143,131	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	55,959	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	23,190,600	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	RURAL DEMONSTRATION PROJECT	0	70.50
70.88	SCH or MDH volume decrease adjustment	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	16,570	70.93
70.94	HRR adjustment amount (see instructions)	-188,389	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150046	Period: From 09/01/2015 To 08/31/2016	Worksheet E Part A Date/Time Prepared: 1/25/2017 6:24 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		23,018,781	71.00
71.01	Sequestration adjustment (see instructions)		460,376	71.01
72.00	Interim payments		22,629,890	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		-71,485	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		301,528	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet E Part B Date/Time Prepared: 1/25/2017 6:24 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	15,924	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	10,892,924	2.00
3.00	PPS payments	10,529,150	3.00
4.00	Outlier payment (see instructions)	51,012	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	15,924	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	133,877	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	133,877	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	133,877	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	117,953	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	15,924	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	10,580,162	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,150,079	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	8,446,007	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	8,446,007	30.00
31.00	Primary payer payments	1,279	31.00
32.00	Subtotal (line 30 minus line 31)	8,444,728	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	535,241	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	347,907	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	377,413	36.00
37.00	Subtotal (see instructions)	8,792,635	37.00
38.00	MSP-LCC reconciliation amount from PS&R	53	38.00
39.00	PS&R 13P OTHER	75,399	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	8,867,981	40.00
40.01	Sequestration adjustment (see instructions)	177,360	40.01
41.00	Interim payments	8,645,081	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	45,540	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

	Provider CCN: 150046 Component CCN: 15S046	Period: From 09/01/2015 To 08/31/2016	Worksheet E Part B Date/Time Prepared: 1/25/2017 6:24 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	365	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	990	2.00
3.00	PPS payments	1,412	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	365	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	3,060	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	3,060	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	3,060	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	2,695	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	365	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	1,412	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	154	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,623	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,623	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,623	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	1,623	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,623	40.00
40.01	Sequestration adjustment (see instructions)	32	40.01
41.00	Interim payments	1,730	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-139	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

	Provider CCN: 150046 Component CCN: 15T046	Period: From 09/01/2015 To 08/31/2016	Worksheet E Part B Date/Time Prepared: 1/25/2017 6:24 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	238	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	192	2.00
3.00	PPS payments	390	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	238	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,994	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	1,994	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	1,994	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,756	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	238	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	390	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	628	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	628	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	628	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	628	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	628	40.00
40.01	Sequestration adjustment (see instructions)	13	40.01
41.00	Interim payments	730	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-115	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet E-1 Part I Date/Time Prepared: 1/25/2017 6:24 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		22,629,890		8,645,081	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)		22,629,890		8,645,081	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		45,540	6.01
6.02	SETTLEMENT TO PROGRAM		71,485		0	6.02
7.00	Total Medicare program liability (see instructions)		22,558,405		8,690,621	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CCN: 150046 Component CCN: 15S046	Period: From 09/01/2015 To 08/31/2016	Worksheet E-1 Part I Date/Time Prepared: 1/25/2017 6:24 pm
	Title XVIII	Subprovider - IPF	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		983,043		1,730	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)		983,043		1,730	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		33,867		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		139	6.02
7.00	Total Medicare program liability (see instructions)		1,016,910		1,591	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CCN: 150046 Component CCN: 15T046	Period: From 09/01/2015 To 08/31/2016	Worksheet E-1 Part I Date/Time Prepared: 1/25/2017 6:24 pm
	Title XVIII	Subprovider - IRF	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		1,775,775		730	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)		1,775,775		730	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		59,410		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		115	6.02
7.00	Total Medicare program liability (see instructions)		1,835,185		615	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150046	Period: From 09/01/2015 To 08/31/2016	Worksheet E-1 Part II Date/Time Prepared: 1/25/2017 6:24 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	5,481	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	12,752	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,721	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	22,647	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	633,950,480	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,962,946	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150046	Period: From 09/01/2015 To 08/31/2016	Worksheet E-3 Part I Date/Time Prepared: 1/25/2017 6:24 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - MEDICARE PART A SERVICES - TEFRA		
1.00	Inpatient hospital services (see instructions)	0	1.00
2.00	Organ acquisition	0	2.00
3.00	Cost of physicians' services in a teaching hospital (see instructions)	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	0	4.00
5.00	Primary payer payments	0	5.00
6.00	Subtotal (line 4 less line 5).	0	6.00
7.00	Deductibles	0	7.00
8.00	Subtotal (line 6 minus line 7)	0	8.00
9.00	Coinsurance	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	10.00
11.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	11.00
12.00	Adjusted reimbursable bad debts (see instructions)	0	12.00
13.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	13.00
14.00	Subtotal (sum of lines 10 and 12)	0	14.00
15.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	15.00
16.00	DO NOT USE THIS LINE		16.00
17.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	17.00
17.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	17.50
17.99	Recovery of Accelerated Depreciation	0	17.99
18.00	Total amount payable to the provider (see instructions)	0	18.00
18.01	Sequestration adjustment (see instructions)	0	18.01
19.00	Interim payments	0	19.00
20.00	Tentative settlement (for contractor use only)	0	20.00
21.00	Balance due provider/program (line 18 minus lines 18.01, 19, and 20)	0	21.00
22.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	22.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150046 Component CCN: 15S046	Period: From 09/01/2015 To 08/31/2016	Worksheet E-3 Part II Date/Time Prepared: 1/25/2017 6:24 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,107,169	1.00
2.00	Net IPF PPS Outlier Payments	89,527	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 instuctions)	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 instuctions)	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)	17.497268	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) 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)	1,196,696	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)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,196,696	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,196,696	18.00
19.00	Deductibles	148,112	19.00
20.00	Subtotal (line 18 minus line 19)	1,048,584	20.00
21.00	Coinsurance	45,479	21.00
22.00	Subtotal (line 20 minus line 21)	1,003,105	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	53,166	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	34,558	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	10,983	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,037,663	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)	1,037,663	31.00
31.01	Sequestration adjustment (see instructions)	20,753	31.01
32.00	Interim payments	983,043	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)	33,867	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	89,527	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: 150046 Component CCN: 15T046	Period: From 09/01/2015 To 08/31/2016	Worksheet E-3 Part III Date/Time Prepared: 1/25/2017 6:24 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	1,517,104	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0448	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	103,315	3.00
4.00	Outlier Payments	266,793	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	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	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	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	7.00
8.00	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	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	4.991803	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	1,887,212	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	1,887,212	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	1,887,212	19.00
20.00	Deductibles	7,644	20.00
21.00	Subtotal (line 19 minus line 20)	1,879,568	21.00
22.00	Coinsurance	6,930	22.00
23.00	Subtotal (line 21 minus line 22)	1,872,638	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	1,872,638	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	1,872,638	32.00
32.01	Sequestration adjustment (see instructions)	37,453	32.01
33.00	Interim payments	1,775,775	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)	59,410	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	266,793	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: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet E-3 Part VII Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	6,981,245		1.00
2.00	Medical and other services		7,827,770	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	6,981,245	7,827,770	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)	6,981,245	7,827,770	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	42,990,020	65,998,514	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)	42,990,020	65,998,514	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	42,990,020	65,998,514	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	36,008,775	58,170,744	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)	6,981,245	7,827,770	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	6,981,245	7,827,770	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
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)	6,981,245	7,827,770	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	6,981,245	7,827,770	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	6,981,245	7,827,770	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)	6,981,245	7,827,770	40.00
41.00	Interim payments	7,139,061	5,054,608	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-157,816	2,773,162	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

CALCULATION OF REIMBURSEMENT SETTLEMENT

	Provider CCN: 150046 Component CCN: 15S046	Period: From 09/01/2015 To 08/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 1/25/2017 6:24 pm
	Title XIX	Subprovider - IPF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	2,658,497		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)	2,658,497	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)	2,658,497	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	3,448,987	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)	3,448,987	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	3,448,987	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	790,490	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)	2,658,497	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	2,658,497	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
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)	2,658,497	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	2,658,497	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	2,658,497	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)	2,658,497	0	40.00
41.00	Interim payments	2,201,794	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	456,703	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

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 150046 | Component CCN: 15T046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet E-3 Part VII | Date/Time Prepared: 1/25/2017 6:24 pm

Title XIX | Subprovider - IRF | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	349,174		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)	349,174	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)	349,174	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	954,110	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)	954,110	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	954,110	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	604,936	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)	349,174	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	349,174	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
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)	349,174	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	349,174	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	349,174	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)	349,174	0	40.00
41.00	Interim payments	204,185	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	144,989	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: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet G | Date/Time Prepared: 1/25/2017 6:24 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-152	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	26,219,531	0	0	0	4.00
5.00	Other receivable	19,764	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,113,208	0	0	0	6.00
7.00	Inventory	6,107,506	0	0	0	7.00
8.00	Prepaid expenses	428,999	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	1,619	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	23,664,059	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,262,718	0	0	0	12.00
13.00	Land improvements	3,158,371	0	0	0	13.00
14.00	Accumulated depreciation	-3,023,197	0	0	0	14.00
15.00	Buildings	38,638,215	0	0	0	15.00
16.00	Accumulated depreciation	-24,840,135	0	0	0	16.00
17.00	Leasehold improvements	7,764,970	0	0	0	17.00
18.00	Accumulated depreciation	-5,456,215	0	0	0	18.00
19.00	Fixed equipment	27,059,404	0	0	0	19.00
20.00	Accumulated depreciation	-18,694,904	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	38,674,454	0	0	0	23.00
24.00	Accumulated depreciation	-29,821,885	0	0	0	24.00
25.00	Minor equipment depreciable	4,757,047	0	0	0	25.00
26.00	Accumulated depreciation	-2,854,497	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	2,301,055	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	38,925,401	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,386,484	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,063,197	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,449,681	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	68,039,141	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	5,044,751	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,585,499	0	0	0	38.00
39.00	Payroll taxes payable	3,129,448	0	0	0	39.00
40.00	Notes and loans payable (short term)	105,677	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	632	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,866,007	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	227,510	0	0	0	47.00
48.00	Unsecured loans	-213,063,279	0	0	0	48.00
49.00	Other long term liabilities	66,434	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-212,769,335	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-200,903,328	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	268,942,469				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)	268,942,469	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	68,039,141	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES	Provider CCN: 150046	Period: From 09/01/2015 To 08/31/2016	Worksheet G-1 Date/Time Prepared: 1/25/2017 6:24 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		264,455,644		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		10,871,240				2.00
3.00	Total (sum of line 1 and line 2)		275,326,884		0		3.00
4.00	ROUNDING	9		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)		9		0		10.00
11.00	Subtotal (line 3 plus line 10)		275,326,893		0		11.00
12.00	FEDERAL TAX LIABILITY ENTRY	6,384,424		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)		6,384,424		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		268,942,469		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	ROUNDING		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	FEDERAL TAX LIABILITY ENTRY		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: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 1/25/2017 6:24 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	21,443,475		21,443,475	1.00
2.00	SUBPROVIDER - IPF	20,479,135		20,479,135	2.00
3.00	SUBPROVIDER - IRF	2,186,183		2,186,183	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	44,108,793		44,108,793	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	8,770,558		8,770,558	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)	8,770,558		8,770,558	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	52,879,351		52,879,351	17.00
18.00	Ancillary services	257,748,445	272,354,820	530,103,265	18.00
19.00	Outpatient services	15,138,826	36,655,271	51,794,097	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		0	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	325,766,622	309,010,091	634,776,713	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		110,799,128		29.00
30.00	GAIN/LOSS ON DISPOSAL	4,755			30.00
31.00	ROUNDING	9			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)		4,764		36.00
37.00	HITECH	4,942			37.00
38.00	ATHLETIC TRAINING	7,950			38.00
39.00	INTEREST INCOME	12,804			39.00
40.00	UNCLAIMED PROPERTY	3,639			40.00
41.00	ROUNDING	1			41.00
42.00	Total deductions (sum of lines 37-41)		29,336		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		110,774,556		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 150046 | Period: From 09/01/2015 To 08/31/2016 | Worksheet G-3 | Date/Time Prepared: 1/25/2017 6:24 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	634,776,713	1.00
2.00	Less contractual allowances and discounts on patients' accounts	513,557,527	2.00
3.00	Net patient revenues (line 1 minus line 2)	121,219,186	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	110,774,556	4.00
5.00	Net income from service to patients (line 3 minus line 4)	10,444,630	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	426,610	24.00
25.00	Total other income (sum of lines 6-24)	426,610	25.00
26.00	Total (line 5 plus line 25)	10,871,240	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)	10,871,240	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150046	Period: From 09/01/2015 To 08/31/2016	Worksheet L Parts I-III Date/Time Prepared: 1/25/2017 6:24 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,713,341	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	97,749	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	62.13	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	5.68	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	18.53	8.00
9.00	Sum of lines 7 and 8	24.21	9.00
10.00	Allowable disproportionate share percentage (see instructions)	5.02	10.00
11.00	Disproportionate share adjustment (see instructions)	86,010	11.00
12.00	Total prospective capital payments (see instructions)	1,897,100	12.00

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00

		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00