

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: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/23/2016 9:25 am
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**PART I - COST REPORT STATUS**

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

**PART II - CERTIFICATION**

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

**CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)**

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MARION GENERAL HOSPITAL ( 150011 ) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) \_\_\_\_\_  
Officer or Administrator of Provider(s)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-519,514	60,053	-69,285	-2,268	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	-15,072	0		0	3.00
4.00 SUBPROVIDER I						4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	-534,586	60,053	-69,285	-2,268	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-MEDI CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150011			Period: From 07/01/2015 To 06/30/2016		Worksheet S-2 Part I Date/Time Prepared: 11/23/2016 9:25 am				
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 441 WABASH AVENUE			PO Box:						1.00	
2.00	City: MARION			State: IN		Zip Code: 46952-		County: GRANT		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
		V		XVIII		XIX					
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		MARION GENERAL HOSPITAL	150011	99915	1	07/01/1966	N	P	0	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF		MARION GENERAL HOSPITAL REHAB	15T011	99915	5	07/01/2005	N	P	0	5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2015	06/30/2016		20.00	
21.00	Type of Control (see instructions)						2			21.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (PickLe amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	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 IPFS 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.	433	1,841	0	0	2,808	0		24.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	157	0	0	35			25.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/23/2016 9:25 am		
		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2				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.	2				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.	1				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.	07/01/2015	06/30/2016			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N				37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	Y			40.00
		V	XVII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	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)				0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05

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

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			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
				1.00		
<b>Long Term Care Hospital PPS</b>						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		
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		
<b>TEFRA Providers</b>						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		
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.			N		
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		
				V	XIX	
				1.00	2.00	
<b>Title V and XIX Services</b>						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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		V 1.00	XIX 2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	0.00	97.00	
<b>Rural Providers</b>						
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	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 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	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	
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	946,761	0	0		118.01
					1.00	
					2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	Y		Y		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N				121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
<b>Transplant Center Information</b>						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/23/2016 9:25 am		
		1.00	2.00			
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				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:	Contractor's Name:		Contractor's Number:		141.00
142.00	Street:	PO Box:				142.00
143.00	City:	State:		Zip Code:		143.00
				1.00		
144.00	Are provider based physicians' costs included in Worksheet A?		Y			144.00
				1.00 2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N				145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00
				1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N			147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N			148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N			149.00
		Part A		Part B		Title V
		1.00		2.00		3.00
						Title XIX
						4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
				1.00		
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.		N			165.00
		Name	County	State	Zip Code	CBSA
		0	1.00	2.00	3.00	4.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00
				1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y			167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		0			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		0.50			169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/23/2016 9:25 am	
			Beginning	Ending	
			1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		07/01/2015	09/30/2015	170.00
			1.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			N	171.00



HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/23/2016 9:25 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		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
			1.00	2.00	3.00
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	10/14/2016	Y	10/14/2016
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/23/2016 9:25 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				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
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				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.				35.00
			Y/N	Date	
			1.00	2.00	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?				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.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00		2.00	
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA		SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946		TSEVERS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150011

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
11/23/2016 9:25 am

		3.00	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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

HFS Supplemental Information		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part IX Date/Time Prepared: 11/23/2016 9:25 am
		Title V 1.00	Title XIX 2.00	
<b>TITLES V AND/OR XIX FOLLOWING MEDICARE</b>				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient 1.00	Outpatient 2.00	
<b>CRITICAL ACCESS HOSPITALS</b>				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V 1.00	Title XIX 2.00	
<b>RCE DISALLOWANCE</b>				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
<b>PASS THROUGH COST</b>				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00
<b>RHC</b>				
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150011

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/23/2016 9:25 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				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	78	28,548	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)		78	28,548	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	19	6,954	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)		97	35,502	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF	41.00	18	6,588		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		115				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150011

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/23/2016 9:25 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	6,946	433	13,720			1.00
2.00 HMO and other (see instructions)	2,187	4,649				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	177	192				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)	6,946	433	13,720			7.00
8.00 INTENSIVE CARE UNIT	1,919	0	4,309			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	2,045			13.00
14.00 Total (see instructions)	8,865	433	20,074	0.00	717.86	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00 SUBPROVIDER - IRF	2,518	0	3,086	0.00	17.84	17.00
18.00 SUBPROVIDER		0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	735.70	27.00
28.00 Observation Bed Days		943	2,872			28.00
29.00 Ambulance Trips	1,348					29.00
30.00 Employee discount days (see instruction)			160			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150011

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/23/2016 9:25 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,190	64	5,198	1.00
2.00 HMO and other (see instructions)			527	1,211		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				13		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	2,190	64	5,198	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	0	230	0	275	17.00
18.00 SUBPROVIDER	0.00	0		0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150011		Period: From 07/01/2015 To 06/30/2016		Worksheet S-3 Part II Date/Time Prepared: 11/23/2016 9:25 am	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
<b>PART II - WAGE DATA</b>								
<b>SALARIES</b>								
1.00	Total salaries (see instructions)	200.00	45,875,160	-170,611	45,704,549	1,829,493.29	24.98	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		35,250	0	35,250	235.00	150.00	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)		7,605,572	334,808	7,940,380	416,906.01	19.05	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11.00	Contract labor: Direct Patient Care		530,969	0	530,969	7,432.05	71.44	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		249,600	0	249,600	1,664.00	150.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	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
<b>WAGE-RELATED COSTS</b>								
17.00	Wage-related costs (core) (see instructions)		14,198,259	0	14,198,259			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		4,262,904	0	4,262,904			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		1,824	0	1,824			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
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits Department	4.00	958,351	59,978	1,018,329	30,790.60	33.07	26.00
27.00	Administrative & General	5.00	8,406,215	-312,687	8,093,528	329,787.00	24.54	27.00
28.00	Administrative & General under contract (see inst.)		3,389,624	0	3,389,624	18,097.00	187.30	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	610,857	-30,566	580,291	32,641.40	17.78	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,561,297	0	1,561,297	109,200.00	14.30	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		1,331,171	0	1,331,171	64,666.00	20.59	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,445,173	-536,488	908,685	19,849.70	45.78	38.00
39.00	Central Services and Supply	14.00	132,746	24,384	157,130	9,472.70	16.59	39.00
40.00	Pharmacy	15.00	2,371,296	-2,452	2,368,844	58,131.10	40.75	40.00



HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150011

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
11/23/2016 9:25 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150011

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
11/23/2016 9:25 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	52,157,252	-170,611	51,986,641	2,021,456.29	25.72	1.00
2.00	Excluded area salaries (see instructions)	7,605,572	334,808	7,940,380	416,906.01	19.05	2.00
3.00	Subtotal salaries (line 1 minus line 2)	44,551,680	-505,419	44,046,261	1,604,550.28	27.45	3.00
4.00	Subtotal other wages & related costs (see inst.)	780,569	0	780,569	9,096.05	85.81	4.00
5.00	Subtotal wage-related costs (see inst.)	14,200,083	0	14,200,083	0.00	32.24	5.00
6.00	Total (sum of lines 3 thru 5)	59,532,332	-505,419	59,026,913	1,613,646.33	36.58	6.00
7.00	Total overhead cost (see instructions)	20,206,730	-797,831	19,408,899	672,635.50	28.86	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 150011

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

Worksheet S-3  
Part IV  
Date/Time Prepared:  
11/23/2016 9:25 am

		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	1,121,032	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	6,620,445	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	219,411	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	8,484,264	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	34,343	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)	445,440	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	479,776	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
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	3,877,249	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	8,283	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
<b>OTHER</b>			
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	324,179	23.00
24.00	<b>Total Wage Related cost (Sum of lines 1 -23)</b>	<b>21,614,422</b>	<b>24.00</b>
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE	151,339	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150011

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

Worksheet S-3  
Part V  
Date/Time Prepared:  
11/23/2016 9:25 am

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet S-10 Date/Time Prepared: 11/23/2016 9:25 am
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				1.00		
<b>Uncompensated and indigent care cost computation</b>						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.295628		1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid		6,255,560		2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0		5.00	
6.00	Medicaid charges		42,961,464		6.00	
7.00	Medicaid cost (line 1 times line 6)		12,700,612		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)		6,445,052		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)		6,445,052		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		6,306,919	2,528,233	8,835,152	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)		1,864,502	747,416	2,611,918	21.00
22.00	Partial payment by patients approved for charity care		14,163	74,965	89,128	22.00
23.00	Cost of charity care (line 21 minus line 22)		1,850,339	672,451	2,522,790	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?					24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit				0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)				14,818,371	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)				736,449	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)				14,081,922	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)				4,163,010	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				6,685,800	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				13,130,852	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 150011		Period: From 07/01/2015 To 06/30/2016		Worksheet A		
Date/Time Prepared: 11/23/2016 9:25 am								
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		12,625,875	12,625,875	-1,135,592	11,490,283	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	958,351	19,178,798	20,137,149	102,414	20,239,563	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,406,215	22,914,910	31,321,125	-149,455	31,171,670	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
6.01	00601	CAFETERIA	0	0	0	1,445,534	1,445,534	6.01
6.02	00602	CAFETERIA	0	0	0	0	0	6.02
7.00	00700	OPERATION OF PLANT	610,857	4,284,783	4,895,640	398,636	5,294,276	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	463,041	463,041	8.00
9.00	00900	HOUSEKEEPING	0	3,058,829	3,058,829	-525,956	2,532,873	9.00
10.00	01000	DIETARY	0	2,022,253	2,022,253	-1,498,363	523,890	10.00
13.00	01300	NURSING ADMINISTRATION	1,445,173	96,939	1,542,112	-536,488	1,005,624	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	132,746	369,970	502,716	24,384	527,100	14.00
15.00	01500	PHARMACY	2,371,296	7,321,596	9,692,892	-4,051,111	5,641,781	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	7,279,242	959,155	8,238,397	-1,140,314	7,098,083	30.00
31.00	03100	INTENSIVE CARE UNIT	2,343,087	315,361	2,658,448	17,987	2,676,435	31.00
40.00	04000	SUBPROVIDER - I/PF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I/RF	976,013	780,481	1,756,494	0	1,756,494	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	1,380,749	1,380,749	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	12,543,511	12,543,511	178,810	12,722,321	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,939,768	2,745,336	5,685,104	-841,905	4,843,199	54.00
57.00	05700	CT SCAN	0	0	0	843,365	843,365	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	453,980	453,980	58.00
59.00	05900	CARDIAC CATHETERIZATION	489,888	1,648,199	2,138,087	35,752	2,173,839	59.00
60.00	06000	LABORATORY	2,357,050	4,525,023	6,882,073	-18,382	6,863,691	60.00
60.01	06001	ONCOLOGY	973,075	593,199	1,566,274	0	1,566,274	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	1,170,072	668,943	1,839,015	71,540	1,910,555	65.00
66.00	06600	PHYSICAL THERAPY	1,783,475	265,084	2,048,559	0	2,048,559	66.00
69.00	06900	ELECTROCARDIOLOGY	689,137	149,071	838,208	74,017	912,225	69.00
69.01	06901	CARDIAC REHAB	101,058	4,298	105,356	37,159	142,515	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,051,111	4,051,111	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	256,515	111,515	368,030	57,468	425,498	90.00
91.00	09100	EMERGENCY	3,962,583	945,516	4,908,099	-54,408	4,853,691	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	996,808	124,001	1,120,809	54,408	1,175,217	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	40,242,409	98,252,646	138,495,055	-261,619	138,233,436	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,930	16,930	26,176	43,106	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	95,383	4,049	99,432	11,200	110,632	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	975,718	975,718	-886,882	88,836	192.05
192.08	19211	PARI SH NURSING	27,367	14,749	42,116	15,459	57,575	192.08
192.09	19212	BIOTERRORISM GRANT	0	25,916	25,916	30,566	56,482	192.09
192.10	19214	BREAST PUMPS	0	0	0	0	0	192.10
192.12	19209	LUNG CENTER	101,833	450,848	552,681	29,560	582,241	192.12
192.14	19210	MGH PHYS PRACT MGMT	925,921	525,316	1,451,237	44,982	1,496,219	192.14
192.15	19215	MGH MARION SURGEONS	462,897	1,956,034	2,418,931	77,163	2,496,094	192.15
192.16	19216	MGH MGH MED ONC	414	1,307,315	1,307,729	0	1,307,729	192.16
192.17	19217	MGH FMC SOUTH	781,855	2,267,678	3,049,533	366,162	3,415,695	192.17
192.18	19218	MGH FAIRM MED ASSOC	5,416	90,420	95,836	307	96,143	192.18
192.19	19219	MGH FMC MARION	226,594	504,867	731,461	28,904	760,365	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	281,595	688,536	970,131	1,239	971,370	193.01
193.02	19302	MGH FMC GAS CITY	153,696	401,882	555,578	59,252	614,830	193.02
193.03	19303	MGH HOSPITALISTS	74,369	2,968,036	3,042,405	0	3,042,405	193.03
193.04	19304	MGH MAR FAM PRACT	752,406	2,055,639	2,808,045	0	2,808,045	193.04
193.05	19305	MGH FMC SWAYZEE	73,226	146,763	219,989	25,686	245,675	193.05
193.06	19306	MGH PEDIATRIC CTR	271,864	1,029,231	1,301,095	63,556	1,364,651	193.06

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 150011		Period: From 07/01/2015 To 06/30/2016		Worksheet A Date/Time Prepared: 11/23/2016 9:25 am	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
193.07	19307	MGH SPECIALTY PHYS	77,700	271,582	349,282	39,399	388,681	193.07
193.08	19308	MGH FMC CONVERSE	108,440	185,806	294,246	307	294,553	193.08
193.09	19309	MGH UPLAND HEALTH	365,258	1,064,986	1,430,244	6,639	1,436,883	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	432,622	1,787,633	2,220,255	0	2,220,255	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	314,811	314,811	194.03
194.04	07953	MGH WORK SOLUTIONS	362,216	478,929	841,145	7,133	848,278	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	51,679	99,301	150,980	0	150,980	194.05
194.08	07957	MGH SMMP BLDG	0	289,770	289,770	0	289,770	194.08
194.09	07958	MGH AMBUCARE BLDG	0	53,441	53,441	0	53,441	194.09
194.10	07959	MGH 106 LYONS BLDG	0	4,708	4,708	0	4,708	194.10
194.11	07960	FAIRMOUNT	0	14,913	14,913	0	14,913	194.11
194.12	07961	GAS CITY	0	57,067	57,067	0	57,067	194.12
194.13	07962	LYONS	0	16,051	16,051	0	16,051	194.13
194.14	07964	WABASH	0	495	495	0	495	194.14
200.00		TOTAL (SUM OF LINES 118-199)	45,875,160	118,007,255	163,882,415	0	163,882,415	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150011

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

Worksheet A  
Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-96,482	11,393,801	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-627,457	19,612,106	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-10,825,419	20,346,251	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
6.01	00601	CAFETERIA	-26,059	1,419,475	6.01
6.02	00602	CAFETERIA	0	0	6.02
7.00	00700	OPERATION OF PLANT	-121,696	5,172,580	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-4,126	458,915	8.00
9.00	00900	HOUSEKEEPING	-2,479	2,530,394	9.00
10.00	01000	DIETARY	-7,915	515,975	10.00
13.00	01300	NURSING ADMINISTRATION	0	1,005,624	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-932	526,168	14.00
15.00	01500	PHARMACY	-34,463	5,607,318	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-35,777	7,062,306	30.00
31.00	03100	INTENSIVE CARE UNIT	-424	2,676,011	31.00
40.00	04000	SUBPROVIDER - I PF	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	-74,262	1,682,232	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	1,380,749	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-13,471	12,708,850	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-162,800	4,680,399	54.00
57.00	05700	CT SCAN	0	843,365	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	453,980	58.00
59.00	05900	CARDIAC CATHETERIZATION	-7,215	2,166,624	59.00
60.00	06000	LABORATORY	-87,687	6,776,004	60.00
60.01	06001	ONCOLOGY	-9,298	1,556,976	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	-4,780	1,905,775	65.00
66.00	06600	PHYSICAL THERAPY	-93	2,048,466	66.00
69.00	06900	ELECTROCARDIOLOGY	-53,950	858,275	69.00
69.01	06901	CARDIAC REHAB	-5	142,510	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-400	4,050,711	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	-196	425,302	90.00
91.00	09100	EMERGENCY	-165,985	4,687,706	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	-57,351	1,117,866	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-12,420,722	125,812,714	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	43,106	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.02	19202	VISITOR MEALS	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	110,632	192.03
192.04	19204	LIFELINE	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	88,836	192.05
192.08	19211	PARISH NURSING	0	57,575	192.08
192.09	19212	BIOTERRORISM GRANT	0	56,482	192.09
192.10	19214	BREAST PUMPS	0	0	192.10
192.12	19209	LUNG CENTER	-30,768	551,473	192.12
192.14	19210	MGH PHYS PRACT MGMT	-64,421	1,431,798	192.14
192.15	19215	MGH MARION SURGEONS	-107,646	2,388,448	192.15
192.16	19216	MGH MGH MED ONC	0	1,307,729	192.16
192.17	19217	MGH FMC SOUTH	-320,299	3,095,396	192.17
192.18	19218	MGH FAIRM MED ASSOC	-15,099	81,044	192.18
192.19	19219	MGH FMC MARION	-45,686	714,679	192.19
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	971,370	193.01
193.02	19302	MGH FMC GAS CITY	-80,641	534,189	193.02
193.03	19303	MGH HOSPITALISTS	0	3,042,405	193.03
193.04	19304	MGH MAR FAM PRACT	0	2,808,045	193.04
193.05	19305	MGH FMC SWAYZEE	-28,965	216,710	193.05
193.06	19306	MGH PEDIATRIC CTR	-89,847	1,274,804	193.06
193.07	19307	MGH SPECIALTY PHYS	-42,576	346,105	193.07
193.08	19308	MGH FMC CONVERSE	0	294,553	193.08



RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150011

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

Worksheet A  
Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
193.09	19309	MGH UPLAND HEALTH	0	1,436,883	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	193.11
193.12	19312	OB/GYN	0	2,220,255	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	194.00
194.01	07950	MOW	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	194.02
194.03	07952	ADVERTISING	0	314,811	194.03
194.04	07953	MGH WORK SOLUTIONS	-103,875	744,403	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	150,980	194.05
194.08	07957	MGH SMMP BLDG	0	289,770	194.08
194.09	07958	MGH AMBUCARE BLDG	0	53,441	194.09
194.10	07959	MGH 106 LYONS BLDG	0	4,708	194.10
194.11	07960	FARMOUNT	0	14,913	194.11
194.12	07961	GAS CITY	0	57,067	194.12
194.13	07962	LYONS	0	16,051	194.13
194.14	07964	WABASH	0	495	194.14
200.00		TOTAL (SUM OF LINES 118-199)	-13,350,545	150,531,870	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 150011

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

Worksheet Non-CMS W  
Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
6.00	MAINTENANCE & REPAIRS	00600		6.00
6.01	CAFETERIA	00601		6.01
6.02	CAFETERIA	00602		6.02
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
40.00	SUBPROVIDER - IPF	04000		40.00
41.00	SUBPROVIDER - IRF	04100		41.00
42.00	SUBPROVIDER	04200		42.00
43.00	NURSERY	04300		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
60.01	ONCOLOGY	06001		60.01
60.02	RADIATION ONCOLOGY	06002		60.02
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
69.00	ELECTROCARDIOLOGY	06900		69.00
69.01	CARDIAC REHAB	06901		69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
92.01	OBSERVATION BEDS (DISTINCT PART)	09201		92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	AMBULANCE SERVICES	09500		95.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.02	VISITOR MEALS	19202		192.02
192.03	GREAT BEGINNINGS/MATERNAL	19203		192.03
192.04	LIFELINE	19204		192.04
192.05	OWNED PROPERTIES	19205		192.05
192.08	PARISH NURSING	19211		192.08
192.09	BIOTERRORISM GRANT	19212		192.09
192.10	BREAST PUMPS	19214		192.10
192.12	LUNG CENTER	19209		192.12
192.14	MGH PHYS PRACT MGMT	19210		192.14
192.15	MGH MARION SURGEONS	19215		192.15
192.16	MGH MGH MED ONC	19216		192.16
192.17	MGH FMC SOUTH	19217		192.17
192.18	MGH FAIRM MED ASSOC	19218		192.18
192.19	MGH FMC MARION	19219		192.19
193.00	NONPAID WORKERS	19300		193.00
193.01	MGH FMC NORTHWOOD	19301		193.01
193.02	MGH FMC GAS CITY	19302		193.02
193.03	MGH HOSPITALISTS	19303		193.03
193.04	MGH MAR FAM PRACT	19304		193.04
193.05	MGH FMC SWAYZEE	19305		193.05
193.06	MGH PEDIATRIC CTR	19306		193.06

COST CENTERS USED IN COST REPORT

Provider CCN: 150011

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

Worksheet Non-CMS W  
Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
	1.00	2.00	
193.07 MGH SPECIALTY PHYS	19307		193.07
193.08 MGH FMC CONVERSE	19308		193.08
193.09 MGH UPLAND HEALTH	19309		193.09
193.10 MGH MGH WOMENS CTR	19310		193.10
193.11 MGH MGH PSYCHIATRY	19311		193.11
193.12 OB/GYN	19312		193.12
193.15 MGH RIVER VIEW BLDG	19315		193.15
194.00 OTHER NONREIMBURSABLE	07963		194.00
194.01 MOW	07950		194.01
194.02 MENTAL HEALTH	07951		194.02
194.03 ADVERTISING	07952		194.03
194.04 MGH WORK SOLUTIONS	07953		194.04
194.05 MGH TAYLOR UNIVERSITY	07954		194.05
194.08 MGH SMMP BLDG	07957		194.08
194.09 MGH AMBUCARE BLDG	07958		194.09
194.10 MGH 106 LYONS BLDG	07959		194.10
194.11 FAIRMOUNT	07960		194.11
194.12 GAS CITY	07961		194.12
194.13 LYONS	07962		194.13
194.14 WABASH	07964		194.14
200.00 TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 150011

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

Worksheet A-6  
Date/Time Prepared:  
11/23/2016 9:25 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
<b>A - SATELLITE OFFICE RECLASS</b>						
1.00	ELECTROCARDIOLOGY	69.00	9,167	1,897	1.00	
2.00	RADIOLOGY-DIAGNOSTIC	54.00	71,733	13,022	2.00	
	O		80,900	14,919		
<b>B - CAFETERIA RECLASS</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	81,863	1.00	
2.00	CAFETERIA	6.01	0	1,445,534	2.00	
	O		0	1,527,397		
<b>C - ADMIN DIRECTOR RECLASS</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	64,684	0	1.00	
2.00	CENTRAL SERVICES & SUPPLY	14.00	24,384	0	2.00	
3.00	ADULTS & PEDIATRICS	30.00	240,435	0	3.00	
4.00	INTENSIVE CARE UNIT	31.00	17,987	0	4.00	
5.00	CARDIAC CATHETERIZATION	59.00	35,752	0	5.00	
6.00	RESPIRATORY THERAPY	65.00	71,540	0	6.00	
7.00	ELECTROCARDIOLOGY	69.00	46,060	0	7.00	
8.00	CARDIAC REHAB	69.01	21,902	0	8.00	
9.00	CLINIC	90.00	24,129	0	9.00	
11.00	AMBULANCE SERVICES	95.00	54,408	0	11.00	
12.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	26,176	0	12.00	
13.00	GREAT BEGINNINGS/MATERNAL	192.03	11,200	0	13.00	
14.00	PARI SH NURSING	192.08	11,433	0	14.00	
15.00	BIOTERRORISM GRANT	192.09	30,566	0	15.00	
	O		680,656	0		
<b>D - ADVERTISING</b>						
1.00	ADVERTISING	194.03	223,044	91,767	1.00	
	O		223,044	91,767		
<b>E - LEASED PROPERTY</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37,730	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	121,095	2.00	
3.00	OPERATION OF PLANT	7.00	0	427,569	3.00	
4.00	HOUSEKEEPING	9.00	0	8,763	4.00	
5.00	DIETARY	10.00	0	28,429	5.00	
6.00	OPERATING ROOM	50.00	0	178,810	6.00	
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	306,332	7.00	
8.00	CT SCAN	57.00	0	20,884	8.00	
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	23,533	9.00	
10.00	LABORATORY	60.00	0	74,623	10.00	
11.00	ELECTROCARDIOLOGY	69.00	0	16,893	11.00	
12.00	CARDIAC REHAB	69.01	0	15,257	12.00	
13.00	CLINIC	90.00	0	33,339	13.00	
14.00	LUNG CENTER	192.12	0	29,560	14.00	
15.00	PARI SH NURSING	192.08	0	4,026	15.00	
16.00	MGH PHYS PRACT MGMT	192.14	0	44,982	16.00	
17.00	MGH MARION SURGEONS	192.15	0	77,163	17.00	
18.00	MGH FMC SOUTH	192.17	0	341,064	18.00	
19.00	MGH FAIRM MED ASSOC	192.18	0	307	19.00	
20.00	MGH FMC MARION	192.19	0	28,904	20.00	
21.00	MGH WORK SOLUTIONS	194.04	0	7,133	21.00	
22.00	MGH FMC NORTHWOOD	193.01	0	1,239	22.00	
23.00	MGH FMC GAS CITY	193.02	0	59,252	23.00	
24.00	MGH FMC SWAYZEE	193.05	0	25,686	24.00	
25.00	MGH PEDIATRIC CTR	193.06	0	63,556	25.00	
26.00	MGH SPECIALTY PHYS	193.07	0	39,399	26.00	
27.00	MGH FMC CONVERSE	193.08	0	307	27.00	
28.00	MGH UPLAND HEALTH	193.09	0	6,639	28.00	
	O		0	2,022,474		
<b>F - PHARMACY RECLASS</b>						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,051,111	1.00	
	O		0	4,051,111		
<b>G - CT/MRI RECLASS</b>						
1.00	CT SCAN	57.00	424,497	396,421	1.00	
2.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	221,675	207,013	2.00	
	O		646,172	603,434		
<b>H - SHORT TERM DISABILITY RECLASS</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,706	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	36,220	2.00	
4.00	PHARMACY	15.00	0	2,452	4.00	
5.00	ADULTS & PEDIATRICS	30.00	0	24,783	5.00	
6.00	INTENSIVE CARE UNIT	31.00	0	14,350	6.00	
7.00	SUBPROVIDER - IRF	41.00	0	5,303	7.00	

RECLASSIFICATIONS

Provider CCN: 150011

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

Worksheet A-6

Date/Time Prepared:  
11/23/2016 9:25 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,442	9.00
11.00	LABORATORY	60.00	0	15,553	11.00
12.00	ONCOLOGY	60.01	0	19,640	12.00
13.00	RESPIRATORY THERAPY	65.00	0	9,721	13.00
14.00	PHYSICAL THERAPY	66.00	0	4,751	14.00
17.00	EMERGENCY	91.00	0	11,974	17.00
18.00	AMBULANCE SERVICES	95.00	0	2,097	18.00
19.00	MGH PHYS PRACT MGMT	192.14	0	106	19.00
20.00	MGH MARION SURGEONS	192.15	0	602	20.00
21.00	MGH FMC SOUTH	192.17	0	2,135	21.00
22.00	MGH FMC MARION	192.19	0	1,078	22.00
23.00	MGH FMC GAS CITY	193.02	0	951	23.00
24.00	MGH MAR FAM PRACT	193.04	0	3,660	24.00
25.00	LUNG CENTER	192.12	0	607	25.00
26.00	MGH PEDIATRIC CTR	193.06	0	2,246	26.00
27.00	MGH SPECIALTY PHYS	193.07	0	284	27.00
28.00	MGH FMC NORTHWOOD	193.01	0	2,815	28.00
30.00	OB/GYN	193.12	0	135	30.00
	O		0	170,611	
<b>I - NURSERY RECLASS</b>					
1.00	NURSERY	43.00	945,953	434,796	1.00
	O		945,953	434,796	
<b>J - SMMP HOUSEKEEPING RECLASS</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	15,821	1.00
2.00	OPERATION OF PLANT	7.00	0	1,633	2.00
3.00	HOUSEKEEPING	9.00	0	360	3.00
4.00	DIETARY	10.00	0	605	4.00
5.00	MGH FMC SOUTH	192.17	0	25,098	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	22,385	6.00
7.00	CT SCAN	57.00	0	1,563	7.00
8.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,759	8.00
9.00	LABORATORY	60.00	0	2,814	9.00
	TOTALS		0	72,038	
<b>K - LAUNDRY RECLASS</b>					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	463,041	1.00
	TOTALS		0	463,041	
500.00	Grand Total: Increases		2,576,725	9,451,588	500.00

RECLASSIFICATIONS

Provider CCN: 150011

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

Worksheet A-6  
Date/Time Prepared:  
11/23/2016 9:25 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - SATELLITE OFFICE RECLASS</b>							
1.00	LABORATORY	60.00	9,167	1,897	0		1.00
2.00	LABORATORY	60.00	71,733	13,022	0		2.00
	0		80,900	14,919			
<b>B - CAFETERIA RECLASS</b>							
1.00	DIETARY	10.00	0	81,863	0		1.00
2.00	DIETARY	10.00	0	1,445,534	0		2.00
	0		0	1,527,397			
<b>C - ADMIN DIRECTOR RECLASS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	53,423	0	0		1.00
2.00	OPERATION OF PLANT	7.00	30,566	0	0		2.00
3.00	NURSING ADMINISTRATION	13.00	536,488	0	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	5,771	0	0		4.00
5.00	EMERGENCY	91.00	54,408	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
	0		680,656	0			
<b>D - ADVERTISING</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	223,044	91,767	0		1.00
	0		223,044	91,767			
<b>E - LEASED PROPERTY</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,135,592	10		1.00
2.00	OWNED PROPERTIES	192.05	0	886,882	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
	0		0	2,022,474			
<b>F - PHARMACY RECLASS</b>							
1.00	PHARMACY	15.00	0	4,051,111	0		1.00
	0		0	4,051,111			
<b>G - CT/MRI RECLASS</b>							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	646,172	603,434	0		1.00
2.00		0.00	0	0	0		2.00
	0		646,172	603,434			
<b>H - SHORT TERM DISABILITY RECLASS</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	4,706	0	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	36,220	0	0		2.00
4.00	PHARMACY	15.00	2,452	0	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	24,783	0	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	14,350	0	0		6.00
7.00	SUBPROVIDER - IRF	41.00	5,303	0	0		7.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	4,442	0	0		9.00
11.00	LABORATORY	60.00	15,553	0	0		11.00

		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
12.00	ONCOLOGY	60.01	19,640	0	0		12.00	
13.00	RESPIRATORY THERAPY	65.00	9,721	0	0		13.00	
14.00	PHYSICAL THERAPY	66.00	4,751	0	0		14.00	
17.00	EMERGENCY	91.00	11,974	0	0		17.00	
18.00	AMBULANCE SERVICES	95.00	2,097	0	0		18.00	
19.00	MGH PHYS PRACT MGMT	192.14	106	0	0		19.00	
20.00	MGH MARION SURGEONS	192.15	602	0	0		20.00	
21.00	MGH FMC SOUTH	192.17	2,135	0	0		21.00	
22.00	MGH FMC MARION	192.19	1,078	0	0		22.00	
23.00	MGH FMC GAS CITY	193.02	951	0	0		23.00	
24.00	MGH MAR FAM PRACT	193.04	3,660	0	0		24.00	
25.00	LUNG CENTER	192.12	607	0	0		25.00	
26.00	MGH PEDIATRIC CTR	193.06	2,246	0	0		26.00	
27.00	MGH SPECIALTY PHYS	193.07	284	0	0		27.00	
28.00	MGH FMC NORTHWOOD	193.01	2,815	0	0		28.00	
30.00	OB/GYN	193.12	135	0	0		30.00	
			170,611	0				
<b>I - NURSERY RECLASS</b>								
1.00	ADULTS & PEDIATRICS	30.00	945,953	434,796	0		1.00	
			945,953	434,796				
<b>J - SMMP HOUSEKEEPING RECLASS</b>								
1.00	HOUSEKEEPING	9.00	0	72,038	0		1.00	
2.00		0.00	0	0	0		2.00	
3.00		0.00	0	0	0		3.00	
4.00		0.00	0	0	0		4.00	
5.00		0.00	0	0	0		5.00	
6.00		0.00	0	0	0		6.00	
7.00		0.00	0	0	0		7.00	
8.00		0.00	0	0	0		8.00	
9.00		0.00	0	0	0		9.00	
	TOTALS		0	72,038				
<b>K - LAUNDRY RECLASS</b>								
1.00	HOUSEKEEPING	9.00	0	463,041	0		1.00	
	TOTALS		0	463,041				
500.00	Grand Total: Decreases		2,747,336	9,280,977			500.00	

RECLASSIFICATIONS

Provider CCN: 150011

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

Worksheet A-6  
Non-CMS Worksheet  
Date/Time Prepared:  
11/23/2016 9:25 am

		Increases			Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
<b>A - SATELLITE OFFICE RECLASS</b>									
1.00	ELECTROCARDIOLOGY	69.00	9,167	1,897	LABORATORY	60.00	9,167	1,897	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	71,733	13,022	LABORATORY	60.00	71,733	13,022	2.00
	0		80,900	14,919	0		80,900	14,919	
<b>B - CAFETERIA RECLASS</b>									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	81,863	DIETARY	10.00	0	81,863	1.00
2.00	CAFETERIA	6.01	0	1,445,534	DIETARY	10.00	0	1,445,534	2.00
	0		0	1,527,397	0		0	1,527,397	
<b>C - ADMINISTRATOR RECLASS</b>									
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	64,684	0	ADMINISTRATIVE & GENERAL	5.00	53,423	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	24,384	0	OPERATION OF PLANT	7.00	30,566	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	240,435	0	NURSING	13.00	536,488	0	3.00
4.00	INTENSIVE CARE UNIT	31.00	17,987	0	ADMINISTRATION	54.00	5,771	0	4.00
5.00	CARDIAC CATHETERIZATION	59.00	35,752	0	RADIOLOGY-DIAGNOSTIC	91.00	54,408	0	5.00
6.00	RESPIRATORY THERAPY	65.00	71,540	0	EMERGENCY	0.00	0	0	6.00
7.00	ELECTROCARDIOLOGY	69.00	46,060	0		0.00	0	0	7.00
8.00	CARDIAC REHAB	69.01	21,902	0		0.00	0	0	8.00
9.00	CLINIC	90.00	24,129	0		0.00	0	0	9.00
11.00	AMBULANCE SERVICES	95.00	54,408	0		0.00	0	0	11.00
12.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	26,176	0		0.00	0	0	12.00
13.00	GREAT	192.03	11,200	0		0.00	0	0	13.00
14.00	BEGINNINGS/MATERNAL	192.08	11,433	0		0.00	0	0	14.00
15.00	PARI SH NURSING	192.09	30,566	0		0.00	0	0	15.00
	BIOTERRORISM GRANT		680,656	0			680,656	0	
<b>D - ADVERTISING</b>									
1.00	ADVERTISING	194.03	223,044	91,767	ADMINISTRATIVE & GENERAL	5.00	223,044	91,767	1.00
	0		223,044	91,767	0		223,044	91,767	
<b>E - LEASED PROPERTY</b>									
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37,730	NEW CAP REL COSTS-BLDG & FIXT OWNED PROPERTIES	1.00	0	1,135,592	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	121,095		192.05	0	886,882	2.00
3.00	OPERATION OF PLANT	7.00	0	427,569		0.00	0	0	3.00
4.00	HOUSEKEEPING	9.00	0	8,763		0.00	0	0	4.00
5.00	DIETARY	10.00	0	28,429		0.00	0	0	5.00
6.00	OPERATING ROOM	50.00	0	178,810		0.00	0	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	306,332		0.00	0	0	7.00
8.00	CT SCAN	57.00	0	20,884		0.00	0	0	8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	23,533		0.00	0	0	9.00
10.00	LABORATORY	60.00	0	74,623		0.00	0	0	10.00
11.00	ELECTROCARDIOLOGY	69.00	0	16,893		0.00	0	0	11.00
12.00	CARDIAC REHAB	69.01	0	15,257		0.00	0	0	12.00
13.00	CLINIC	90.00	0	33,339		0.00	0	0	13.00
14.00	LUNG CENTER	192.12	0	29,560		0.00	0	0	14.00
15.00	PARI SH NURSING	192.08	0	4,026		0.00	0	0	15.00
16.00	MGH PHYS PRACT MGMT	192.14	0	44,982		0.00	0	0	16.00
17.00	MGH MARION SURGEONS	192.15	0	77,163		0.00	0	0	17.00
18.00	MGH FMC SOUTH	192.17	0	341,064		0.00	0	0	18.00
19.00	MGH FAIRM MED ASSOC	192.18	0	307		0.00	0	0	19.00
20.00	MGH FMC MARION	192.19	0	28,904		0.00	0	0	20.00
21.00	MGH WORK SOLUTIONS	194.04	0	7,133		0.00	0	0	21.00
22.00	MGH FMC NORTHWOOD	193.01	0	1,239		0.00	0	0	22.00
23.00	MGH FMC GAS CITY	193.02	0	59,252		0.00	0	0	23.00
24.00	MGH FMC SWAYZEE	193.05	0	25,686		0.00	0	0	24.00
25.00	MGH PEDIATRIC CTR	193.06	0	63,556		0.00	0	0	25.00
26.00	MGH SPECIALTY PHYS	193.07	0	39,399		0.00	0	0	26.00
27.00	MGH FMC CONVERSE	193.08	0	307		0.00	0	0	27.00
28.00	MGH UPLAND HEALTH	193.09	0	6,639		0.00	0	0	28.00
	0		0	2,022,474	0		0	2,022,474	
<b>F - PHARMACY RECLASS</b>									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,051,111	PHARMACY	15.00	0	4,051,111	1.00
	0		0	4,051,111	0		0	4,051,111	



RECLASSIFICATIONS

Provider CCN: 150011

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

Worksheet A-6  
Non-CMS Worksheet  
Date/Time Prepared:  
11/23/2016 9:25 am

		Increases			Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
<b>G - CT/MRI RECLASS</b>									
1.00	CT SCAN	57.00	424,497	396,421	RADIOLOGY-DIAGNOSTIC	54.00	646,172	603,434	1.00
2.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	221,675	207,013		0.00	0	0	2.00
	O		646,172	603,434	O		646,172	603,434	
<b>H - SHORT TERM DISABILITY RECLASS</b>									
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,706	EMPLOYEE BENEFITS DEPARTMENT	4.00	4,706	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	36,220	ADMINISTRATIVE & GENERAL	5.00	36,220	0	2.00
4.00	PHARMACY	15.00	0	2,452	PHARMACY	15.00	2,452	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	24,783	ADULTS & PEDIATRICS	30.00	24,783	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	0	14,350	INTENSIVE CARE UNIT	31.00	14,350	0	6.00
7.00	SUBPROVIDER - IRF	41.00	0	5,303	SUBPROVIDER - IRF	41.00	5,303	0	7.00
9.00	RADIOLOGY-DIAGNOSTIC LABORATORY	54.00	0	4,442	RADIOLOGY-DIAGNOSTIC LABORATORY	54.00	4,442	0	9.00
11.00	LABORATORY	60.00	0	15,553	LABORATORY	60.00	15,553	0	11.00
12.00	ONCOLOGY	60.01	0	19,640	ONCOLOGY	60.01	19,640	0	12.00
13.00	RESPIRATORY THERAPY	65.00	0	9,721	RESPIRATORY THERAPY	65.00	9,721	0	13.00
14.00	PHYSICAL THERAPY	66.00	0	4,751	PHYSICAL THERAPY	66.00	4,751	0	14.00
17.00	EMERGENCY	91.00	0	11,974	EMERGENCY	91.00	11,974	0	17.00
18.00	AMBULANCE SERVICES	95.00	0	2,097	AMBULANCE SERVICES	95.00	2,097	0	18.00
19.00	MGH PHYS PRACT MGMT	192.14	0	106	MGH PHYS PRACT MGMT	192.14	106	0	19.00
20.00	MGH MARION SURGEONS	192.15	0	602	MGH MARION SURGEONS	192.15	602	0	20.00
21.00	MGH FMC SOUTH	192.17	0	2,135	MGH FMC SOUTH	192.17	2,135	0	21.00
22.00	MGH FMC MARION	192.19	0	1,078	MGH FMC MARION	192.19	1,078	0	22.00
23.00	MGH FMC GAS CITY	193.02	0	951	MGH FMC GAS CITY	193.02	951	0	23.00
24.00	MGH MAR FAM PRACT	193.04	0	3,660	MGH MAR FAM PRACT	193.04	3,660	0	24.00
25.00	LUNG CENTER	192.12	0	607	LUNG CENTER	192.12	607	0	25.00
26.00	MGH PEDIATRIC CTR	193.06	0	2,246	MGH PEDIATRIC CTR	193.06	2,246	0	26.00
27.00	MGH SPECIALTY PHYS	193.07	0	284	MGH SPECIALTY PHYS	193.07	284	0	27.00
28.00	MGH FMC NORTHWOOD	193.01	0	2,815	MGH FMC NORTHWOOD	193.01	2,815	0	28.00
30.00	OB/GYN	193.12	0	135	OB/GYN	193.12	135	0	30.00
	O		0	170,611	O		170,611	0	
<b>I - NURSERY RECLASS</b>									
1.00	NURSERY	43.00	945,953	434,796	ADULTS & PEDIATRICS	30.00	945,953	434,796	1.00
	O		945,953	434,796	O		945,953	434,796	
<b>J - SMMP HOUSEKEEPING RECLASS</b>									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	15,821	HOUSEKEEPING	9.00	0	72,038	1.00
2.00	OPERATION OF PLANT	7.00	0	1,633		0.00	0	0	2.00
3.00	HOUSEKEEPING	9.00	0	360		0.00	0	0	3.00
4.00	DIETARY	10.00	0	605		0.00	0	0	4.00
5.00	MGH FMC SOUTH	192.17	0	25,098		0.00	0	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	22,385		0.00	0	0	6.00
7.00	CT SCAN	57.00	0	1,563		0.00	0	0	7.00
8.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,759		0.00	0	0	8.00
9.00	LABORATORY	60.00	0	2,814		0.00	0	0	9.00
	TOTALS		0	72,038	TOTALS		0	72,038	
<b>K - LAUNDRY RECLASS</b>									
1.00	LAUNDRY & LINEN SERVICE	8.00	0	463,041	HOUSEKEEPING	9.00	0	463,041	1.00
	TOTALS		0	463,041	TOTALS		0	463,041	
500.00	Grand Total: Increases		2,576,725	9,451,588	Grand Total: Decreases		2,747,336	9,280,977	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150011

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
11/23/2016 9:25 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	4,422,249	224,300	0	224,300	0	1.00
2.00	Land Improvements	3,341,756	11,775	0	11,775	0	2.00
3.00	Buildings and Fixtures	108,209,879	5,845,416	0	5,845,416	147,914	3.00
4.00	Building Improvements	871,325	1,602,347	0	1,602,347	0	4.00
5.00	Fixed Equipment	1,005,608	0	0	0	0	5.00
6.00	Movable Equipment	77,858,280	4,067,022	0	4,067,022	3,231,756	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	195,709,097	11,750,860	0	11,750,860	3,379,670	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	195,709,097	11,750,860	0	11,750,860	3,379,670	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	4,646,549	0				1.00
2.00	Land Improvements	3,353,531	0				2.00
3.00	Buildings and Fixtures	113,907,381	0				3.00
4.00	Building Improvements	2,473,672	0				4.00
5.00	Fixed Equipment	1,005,608	0				5.00
6.00	Movable Equipment	78,693,546	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	204,080,287	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	204,080,287	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150011

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	12,625,875	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	12,625,875	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	12,625,875				
3.00	Total (sum of lines 1-2)	0	12,625,875				

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150011

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	72,735,296	0	72,735,296	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	72,735,296	0	72,735,296	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	12,626,664	-1,135,592	1.00
3.00	Total (sum of lines 1-2)	0	0	0	12,626,664	-1,135,592	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	-97,271	0	0	0	11,393,801	1.00
3.00	Total (sum of lines 1-2)	-97,271	0	0	0	11,393,801	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150011

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

Worksheet A-8

Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	*** Cost Center Deleted ***	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	-398,400	0			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1		0			0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-20,340	0	CAFETERIA	6.01	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	*** Cost Center Deleted ***	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			0		0.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150011

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

Worksheet A-8

Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00
33.01	RETURNED CHECK FEE	B	-720	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	PHYSICIAN PRIV APPLIC	B	-3,500	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-75,130	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	CHILD SEAT SAFETY INSPECTION	B	-1,613	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	HEALTH SCREENING FEES - LAB	B	-15,656	LABORATORY	60.00	0	33.05
33.06	HEALTH SCREENING FEES - RAD	B	-8,104	RADIOLOGY-DIAGNOSTIC	54.00	0	33.06
33.07	MED STAFF OTHER SCREENING-MED STAFF	B	2,074	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	HEALTH SCREENING FEES	B	-2,710	LABORATORY	60.00	0	33.08
33.09	FLU SHOT HEALTH SCREENS	B	-10	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	REBATE	B	-61,905	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	RENTAL OF PROVIDER SPACE BY SUPPLIER	B	-1,200	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	RENT SPACE UPLAND	B	-23,367	LABORATORY	60.00	0	33.12
33.13	PAGER RENTAL	B	-2,490	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	SALE OF SCRAP, WASTE, ETC,	B	-7,049	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	SALE OF XRAY FILM	B	-53	RADIOLOGY-DIAGNOSTIC	54.00	0	33.15
33.16	EMPL UNI FORMS	B	-28	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	PCC MARKETING AG	B	-1,525	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	EDUCATIONAL WORKSHOP	B	-3,247	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	OPT HEALTH LINEN SEV	B	-4,126	LAUNDRY & LINEN SERVICE	8.00	0	33.19
33.20	AMBULANCE SVC - ASSISTANTS	B	-51,875	AMBULANCE SERVICES	95.00	0	33.20
33.21	AMBULANCE SVC - CORONER SVC	B	-372	AMBULANCE SERVICES	95.00	0	33.21
33.22	AMBULANCE SVC - LINEN SERVICES	B	-4,224	AMBULANCE SERVICES	95.00	0	33.22
33.23	AMBULANCE SVC - COMMUNITY EVENT STAFF	B	-740	AMBULANCE SERVICES	95.00	0	33.23
33.24	CONTRACT ARU OTH ARU MEDICAL DIRECTOR	B	-58,258	SUBPROVIDER - IRF	41.00	0	33.24
33.25	SCHOOL PHYS OTH SCHOOL PHYS	B	-3,000	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	PHLEBOTOMY	B	-8,850	LABORATORY	60.00	0	33.26
33.27	PRECEPT OTHER PHARMACY STUDENT	B	-400	DRUGS CHARGED TO PATIENTS	73.00	0	33.27
33.28	CLINICAL STUDY- OTHER	B	-7,852	ONCOLOGY	60.01	0	33.28
33.29	SICK CHILD CARE PROGRAM	B	-1,105	ADULTS & PEDIATRICS	30.00	0	33.29
33.30	UNCLAIMED OTHER STATE MONIES RECOVER	B	-102	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	UNCLAIMED OTHER 125 MED/CHILD CARE	B	-4,711	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32	UNCLAIMED OTHER MONIES RECOVERED	B	-216	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	VENDING MACHINES	B	-5,719	CAFETERIA	6.01	0	33.33
33.34	CPR TRAIN OTH AHA COMMUNITY	B	-9,613	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35	PHYSICIAN RECRUITMENT	A	-1,058,627	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36	ED ANESTHESIOLOGIST	A	-1,383,749	ADMINISTRATIVE & GENERAL	5.00	0	33.36
33.37	GAIN ON DISPOSAL	A	-363,138	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.38	TELEVISION AND RADIO SERVICE	A	-17,642	OPERATION OF PLANT	7.00	0	33.38
33.39	TELEPHONE SERVICE	A	-9,792	ADMINISTRATIVE & GENERAL	5.00	0	33.39
33.40	TELEPHONE SERVICE	A	-101,904	OPERATION OF PLANT	7.00	0	33.40
33.41	MISC REV	B	-3,030	ADMINISTRATIVE & GENERAL	5.00	0	33.41
33.42	MISC REV	B	-484	ONCOLOGY	60.01	0	33.42
33.43	ENTERTAINMENT EXP	A	-2,256	ADMINISTRATIVE & GENERAL	5.00	0	33.43
33.44	EMPLOYEE USE OF AUTO	A	-5,441	ADMINISTRATIVE & GENERAL	5.00	0	33.44
33.45	DONATIONS	A	-215,290	ADMINISTRATIVE & GENERAL	5.00	0	33.45
33.46	VHA OPPORTUNITY	A	-3,027	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.46
33.47	VHA OPPORTUNITY	A	-17,695	ADMINISTRATIVE & GENERAL	5.00	0	33.47
33.48	VHA OPPORTUNITY	A	-2,150	OPERATION OF PLANT	7.00	0	33.48
33.49	VHA OPPORTUNITY	A	-2,479	HOUSEKEEPING	9.00	0	33.49
33.50	VHA OPPORTUNITY	A	-7,915	DIETARY	10.00	0	33.50
33.51	VHA OPPORTUNITY	A	-932	CENTRAL SERVICES & SUPPLY	14.00	0	33.51
33.52	VHA OPPORTUNITY	A	-34,146	PHARMACY	15.00	0	33.52
33.53	VHA OPPORTUNITY	A	-34,672	ADULTS & PEDIATRICS	30.00	0	33.53
33.54	VHA OPPORTUNITY	A	-424	INTENSIVE CARE UNIT	31.00	0	33.54
33.55	VHA OPPORTUNITY	A	-104	SUBPROVIDER - IRF	41.00	0	33.55
33.56	VHA OPPORTUNITY	A	-13,471	OPERATING ROOM	50.00	0	33.56
33.57	VHA OPPORTUNITY	A	-4,643	RADIOLOGY-DIAGNOSTIC	54.00	0	33.57
33.58	VHA OPPORTUNITY	A	-7,215	CARDIAC CATHETERIZATION	59.00	0	33.58
33.59	VHA OPPORTUNITY	A	-25,504	LABORATORY	60.00	0	33.59
33.60	VHA OPPORTUNITY	A	-289	ONCOLOGY	60.01	0	33.60
33.61	VHA OPPORTUNITY	A	-2,682	RESPIRATORY THERAPY	65.00	0	33.61

Provider CCN: 150011

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

Worksheet A-8

Date/Time Prepared:  
 11/23/2016 9:25 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.62 VHA OPPORTUNITY	A	-93	PHYSICAL THERAPY		66.00	0 33.62
33.63 VHA OPPORTUNITY	A	-148	ELECTROCARDIOLOGY		69.00	0 33.63
33.64 VHA OPPORTUNITY	A	-5	CARDIAC REHAB		69.01	0 33.64
33.65 VHA OPPORTUNITY	A	-196	CLINIC		90.00	0 33.65
33.66 VHA OPPORTUNITY	A	-985	EMERGENCY		91.00	0 33.66
33.67 VHA OPPORTUNITY	A	-140	AMBULANCE SERVICES		95.00	0 33.67
33.68 FINANCE BANK SERVICE CHARGES	A	-183,558	ADMINISTRATIVE & GENERAL		5.00	0 33.68
33.69 FINANCE DISCOUNT PAYMENTS	A	5,721	ADMINISTRATIVE & GENERAL		5.00	0 33.69
33.70 NONALLOWABLE 2008 BONDS	A	-64,452	NEW CAP REL COSTS-BLDG & FI XT		1.00	11 33.70
33.71 BLDG COSTS	A	789	NEW CAP REL COSTS-BLDG & FI XT		1.00	9 33.71
33.72 ELIMINATING ENTRIES	A	-64,421	MGH PHYS PRACT MGMT		192.14	0 33.72
33.73 ELIMINATING ENTRIES	A	-103,875	MGH WORK SOLUTIONS		194.04	0 33.73
33.74 ELIMINATING ENTRIES	A	-30,768	LUNG CENTER		192.12	0 33.74
33.75 ELIMINATING ENTRIES	A	-107,646	MGH MARION SURGEONS		192.15	0 33.75
33.76 ELIMINATING ENTRIES	A	-320,299	MGH FMC SOUTH		192.17	0 33.76
33.77 ELIMINATING ENTRIES	A	-15,099	MGH FAIRM MED ASSOC		192.18	0 33.77
33.78 ELIMINATING ENTRIES	A	-45,686	MGH FMC MARION		192.19	0 33.78
33.79 ELIMINATING ENTRIES	A	-80,641	MGH FMC GAS CITY		193.02	0 33.79
33.80 ELIMINATING ENTRIES	A	-28,965	MGH FMC SWAYZEE		193.05	0 33.80
33.81 ELIMINATING ENTRIES	A	-89,847	MGH PEDIATRIC CTR		193.06	0 33.81
33.82 ELIMINATING ENTRIES	A	-42,576	MGH SPECIALTY PHYS		193.07	0 33.82
33.84 LOBBYING COSTS	A	-21,917	ADMINISTRATIVE & GENERAL		5.00	0 33.84
33.85 LOBBYING COSTS	A	-317	PHARMACY		15.00	0 33.85
33.86 LOBBYING COSTS	A	-673	ONCOLOGY		60.01	0 33.86
33.87 OPERATING INTEREST INCOME	B	-32,819	NEW CAP REL COSTS-BLDG & FI XT		1.00	11 33.87
33.88 ED ON CALL SVC A/C 7000.2512	A	-2,338,803	ADMINISTRATIVE & GENERAL		5.00	0 33.88
33.89 XIX ASSESSMENT FEE A/C 7200.7892	A	-5,053,859	ADMINISTRATIVE & GENERAL		5.00	0 33.89
33.90 SELF INSURANCE EXPENSE	A	-1,051,698	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.90
33.91 PENSION PLAN ADJUSTMENT	A	427,268	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.91
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,350,545				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150011

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

Worksheet A-8-2

Date/Time Prepared:  
11/23/2016 9:25 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	41.00	SUBPROVIDER - IRF	15,900	15,900	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	53,802	53,802	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	2,098	2,098	0	0	0	3.00
4.00	91.00	EMERGENCY	165,000	165,000	0	0	0	4.00
5.00	60.00	LABORATORY	11,600	11,600	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	150,000	150,000	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			398,400	398,400	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	41.00	SUBPROVIDER - IRF	0	0	0	15,900	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	53,802	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	2,098	3.00
4.00	91.00	EMERGENCY	0	0	0	165,000	4.00
5.00	60.00	LABORATORY	0	0	0	11,600	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	150,000	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	398,400	200.00



COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150011

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	11,393,801	11,393,801				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	19,612,106	434,169	20,046,275			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	20,346,251	1,888,255	3,630,756	25,865,262	25,865,262	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
6.01 00601	CAFETERIA	1,419,475	150,926	0	1,570,401	325,819	6.01
6.02 00602	CAFETERIA	0	0	0	0	0	6.02
7.00 00700	OPERATION OF PLANT	5,172,580	2,940,088	260,319	8,372,987	1,737,185	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	458,915	65,894	0	524,809	108,885	8.00
9.00 00900	HOUSEKEEPING	2,530,394	102,300	0	2,632,694	546,218	9.00
10.00 01000	DIETARY	515,975	208,590	0	724,565	150,329	10.00
13.00 01300	NURSING ADMINISTRATION	1,005,624	21,819	407,637	1,435,080	297,743	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	526,168	74,310	70,489	670,967	139,209	14.00
15.00 01500	PHARMACY	5,607,318	95,225	1,062,666	6,765,209	1,403,612	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	7,062,306	1,346,612	2,937,861	11,346,779	2,354,173	30.00
31.00 03100	INTENSIVE CARE UNIT	2,676,011	312,013	1,052,743	4,040,767	838,358	31.00
40.00 04000	SUBPROVIDER - I PF	0	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - I RF	1,682,232	298,766	435,461	2,416,459	501,355	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	1,380,749	0	424,355	1,805,104	374,514	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	12,708,850	1,077,863	0	13,786,713	2,860,457	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,680,399	644,785	1,056,507	6,381,691	1,324,041	54.00
57.00 05700	CT SCAN	843,365	47,410	190,430	1,081,205	224,323	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	453,980	55,607	99,444	609,031	126,359	58.00
59.00 05900	CARDIAC CATHETERIZATION	2,166,624	157,097	235,803	2,559,524	531,037	59.00
60.00 06000	LABORATORY	6,776,004	397,170	1,014,106	8,187,280	1,698,656	60.00
60.01 06001	ONCOLOGY	1,556,976	0	427,712	1,984,688	411,773	60.01
60.02 06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00 06500	RESPIRATORY THERAPY	1,905,775	143,164	552,628	2,601,567	539,760	65.00
66.00 06600	PHYSICAL THERAPY	2,048,466	27,461	797,937	2,873,864	596,255	66.00
69.00 06900	ELECTROCARDIOLOGY	858,275	247,927	333,922	1,440,124	298,790	69.00
69.01 06901	CARDIAC REHAB	142,510	40,428	55,160	238,098	49,399	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	4,050,711	0	0	4,050,711	840,421	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000	CLINIC	425,302	88,274	125,897	639,473	132,675	90.00
91.00 09100	EMERGENCY	4,687,706	345,552	1,747,840	6,781,098	1,406,908	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00 09500	AMBULANCE SERVICES	1,117,866	129,450	470,636	1,717,952	356,432	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	125,812,714	11,341,155	17,390,309	123,104,102	20,174,686	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	43,106	41,986	11,743	96,835	20,091	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02 19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03 19203	GREAT BEGINNINGS/MATERNAL	110,632	0	47,813	158,445	32,873	192.03
192.04 19204	LIFELINE	0	0	0	0	0	192.04
192.05 19205	OWNED PROPERTIES	88,836	0	0	88,836	18,431	192.05
192.08 19211	PARI SH NURSING	57,575	10,660	17,406	85,641	17,768	192.08
192.09 19212	BIOTERRORISM GRANT	56,482	0	13,712	70,194	14,564	192.09
192.10 19214	BREAST PUMPS	0	0	0	0	0	192.10
192.12 19209	LUNG CENTER	551,473	0	45,410	596,883	123,838	192.12
192.14 19210	MGH PHYS PRACT MGMT	1,431,798	0	415,322	1,847,120	383,231	192.14
192.15 19215	MGH MARION SURGEONS	2,388,448	0	207,386	2,595,834	538,571	192.15
192.16 19216	MGH MGH MED ONC	1,307,729	0	186	1,307,915	271,360	192.16
192.17 19217	MGH FMC SOUTH	3,095,396	0	349,783	3,445,179	714,789	192.17
192.18 19218	MGH FAIRM MED ASSOC	81,044	0	2,430	83,474	17,319	192.18
192.19 19219	MGH FMC MARION	714,679	0	101,167	815,846	169,268	192.19
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301	MGH FMC NORTHWOOD	971,370	0	125,061	1,096,431	227,482	193.01
193.02 19302	MGH FMC GAS CITY	534,189	0	68,522	602,711	125,047	193.02
193.03 19303	MGH HOSPITALISTS	3,042,405	0	33,362	3,075,767	638,145	193.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150011

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

Worksheet B  
Part I  
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11/23/2016 9:25 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
193.04 19304 MGH MAR FAM PRACT	2,808,045	0		335,888	3,143,933	652,287	193.04
193.05 19305 MGH FMC SWAYZEE	216,710	0		32,849	249,559	51,777	193.05
193.06 19306 MGH PEDIATRIC CTR	1,274,804	0		120,951	1,395,755	289,584	193.06
193.07 19307 MGH SPECIALTY PHYS	346,105	0		34,729	380,834	79,014	193.07
193.08 19308 MGH FMC CONVERSE	294,553	0		48,646	343,199	71,205	193.08
193.09 19309 MGH UPLAND HEALTH	1,436,883	0		163,855	1,600,738	332,113	193.09
193.10 19310 MGH MGH WOMENS CTR	0	0		0	0	0	193.10
193.11 19311 MGH MGH PSYCHIATRY	0	0		0	0	0	193.11
193.12 19312 OB/GYN	2,220,255	0		194,014	2,414,269	500,900	193.12
193.15 19315 MGH RIVER VIEW BLDG	0	0		0	0	0	193.15
194.00 07963 OTHER NONREIMBURSABLE	0	0		0	0	0	194.00
194.01 07950 MOW	0	0		0	0	0	194.01
194.02 07951 MENTAL HEALTH	0	0		0	0	0	194.02
194.03 07952 ADVERTISING	314,811	0		100,058	414,869	86,075	194.03
194.04 07953 MGH WORK SOLUTIONS	744,403	0		162,490	906,893	188,158	194.04
194.05 07954 MGH TAYLOR UNIVERSITY	150,980	0		23,183	174,163	36,134	194.05
194.08 07957 MGH SMMP BLDG	289,770	0		0	289,770	60,120	194.08
194.09 07958 MGH AMBUCARE BLDG	53,441	0		0	53,441	11,088	194.09
194.10 07959 MGH 106 LYONS BLDG	4,708	0		0	4,708	977	194.10
194.11 07960 FAIRMOUNT	14,913	0		0	14,913	3,094	194.11
194.12 07961 GAS CITY	57,067	0		0	57,067	11,840	194.12
194.13 07962 LYONS	16,051	0		0	16,051	3,330	194.13
194.14 07964 WABASH	495	0		0	495	103	194.14
200.00 Cross Foot Adjustments					0		200.00
201.00 Negative Cost Centers					0		201.00
202.00 TOTAL (sum lines 118-201)	150,531,870	11,393,801		20,046,275	150,531,870	25,865,262	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150011

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description		MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		6.00	6.01	6.02	7.00	8.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
6.01	00601	CAFETERIA	0	1,896,220			6.01
6.02	00602	CAFETERIA	0	1,824,541	1,824,541		6.02
7.00	00700	OPERATION OF PLANT	0	0	44,108	10,154,280	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	111,883	745,577
9.00	00900	HOUSEKEEPING	0	0	0	173,700	8,200
10.00	01000	DIETARY	0	0	0	354,174	12,320
13.00	01300	NURSING ADMINISTRATION	0	0	27,187	37,047	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	12,936	126,173	8,396
15.00	01500	PHARMACY	0	0	78,895	161,686	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	0	328,713	2,286,461	177,782
31.00	03100	INTENSIVE CARE UNIT	0	0	110,061	529,778	45,766
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	49,741	507,285	24,377
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	43,358	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	226,757	1,830,144	103,941
51.00	05100	RECOVERY ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	124,618	1,094,805	66,640
57.00	05700	CT SCAN	0	0	23,090	80,499	17,203
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	12,058	94,418	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	26,968	266,742	19,728
60.00	06000	LABORATORY	0	0	126,616	674,369	0
60.01	06001	ONCOLOGY	0	0	0	0	0
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	55,620	243,084	2,732
66.00	06600	PHYSICAL THERAPY	0	0	37,903	46,627	24,815
69.00	06900	ELECTROCARDIOLOGY	0	0	42,879	420,965	4,810
69.01	06901	CARDIAC REHAB	0	0	6,426	68,644	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	12,095	149,883	2,342
91.00	09100	EMERGENCY	0	0	196,907	586,726	187,720
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	68,159	219,797	38,676
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,824,541	1,655,095	10,064,890	745,448
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1,115	71,290	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.02	19202	VISITOR MEALS	0	71,679	0	0	0
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	0
192.04	19204	LIFELINE	0	0	0	0	0
192.05	19205	OWNED PROPERTIES	0	0	0	0	0
192.08	19211	PARISH NURSING	0	0	2,319	18,100	0
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0
192.10	19214	BREAST PUMPS	0	0	0	0	0
192.12	19209	LUNG CENTER	0	0	8,913	0	0
192.14	19210	MGH PHYS PRACT MGMT	0	0	63,247	0	0
192.15	19215	MGH MARION SURGEONS	0	0	35,134	0	0
192.16	19216	MGH MGH MED ONC	0	0	0	0	0
192.17	19217	MGH FMC SOUTH	0	0	0	0	129
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	0
192.19	19219	MGH FMC MARION	0	0	19,155	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	MGH FMC NORTHWOOD	0	0	0	0	0
193.02	19302	MGH FMC GAS CITY	0	0	0	0	0
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0
193.04	19304	MGH MAR FAM PRACT	0	0	0	0	0
193.05	19305	MGH FMC SWAYZEE	0	0	0	0	0
193.06	19306	MGH PEDIATRIC CTR	0	0	23,787	0	0
193.07	19307	MGH SPECIALTY PHYS	0	0	5,787	0	0
193.08	19308	MGH FMC CONVERSE	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150011

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description			MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE		
			6.00	6.01	6.02	7.00	8.00		
193.09	19309	MGH UPLAND HEALTH	0	0	0	0	0	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	0	0	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	9,989	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	0	0	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	0	194.12
194.13	07962	LYONS	0	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	0	194.14
200.00		Cross Foot Adjustments							200.00
201.00		Negative Cost Centers	0	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,896,220	1,824,541	10,154,280	745,577	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150011

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

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Cost Center Description		HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
6.01	00601						6.01
6.02	00602						6.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	3,360,812					9.00
10.00	01000	45,842	1,287,230				10.00
13.00	01300	14,326	0	1,811,383			13.00
14.00	01400	71,629	0	0	1,029,310		14.00
15.00	01500	45,842	0	0	0	8,455,244	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	664,714	732,257	489,454	262,476	0	30.00
31.00	03100	183,369	155,968	163,879	102,931	0	31.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	160,448	124,238	74,064	20,586	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	64,559	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	469,883	0	337,639	176,527	0	50.00
51.00	05100	0	0	0	0	0	51.00
54.00	05400	143,257	0	0	20,586	0	54.00
57.00	05700	8,595	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	57,303	0	40,154	30,879	0	59.00
60.00	06000	160,448	0	0	61,759	0	60.00
60.01	06001	0	0	0	2,573	0	60.01
60.02	06002	0	0	0	0	0	60.02
65.00	06500	120,336	0	90,462	56,612	0	65.00
66.00	06600	0	0	56,437	0	0	66.00
69.00	06900	77,359	0	63,846	15,440	0	69.00
69.01	06901	85,954	0	9,569	0	0	69.01
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	8,455,244	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	57,303	0	18,009	0	0	90.00
91.00	09100	641,792	11,486	293,193	113,224	0	91.00
92.00	09200						92.00
92.01	09201	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	20,056	0	101,488	10,293	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		3,028,456	1,023,949	1,802,753	873,886	8,455,244	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	5,730	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	8,630	0	0	192.03
192.04	19204	0	0	0	0	0	192.04
192.05	19205	183,369	0	0	0	0	192.05
192.08	19211	5,730	0	0	0	0	192.08
192.09	19212	0	0	0	0	0	192.09
192.10	19214	0	0	0	0	0	192.10
192.12	19209	0	0	0	0	0	192.12
192.14	19210	22,921	0	0	0	0	192.14
192.15	19215	0	0	0	29,335	0	192.15
192.16	19216	0	0	0	0	0	192.16
192.17	19217	114,606	0	0	20,586	0	192.17
192.18	19218	0	0	0	0	0	192.18
192.19	19219	0	0	0	20,586	0	192.19
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	2,573	0	193.01
193.02	19302	0	0	0	15,440	0	193.02
193.03	19303	0	0	0	0	0	193.03
193.04	19304	0	0	0	30,879	0	193.04
193.05	19305	0	0	0	2,573	0	193.05
193.06	19306	0	0	0	2,573	0	193.06
193.07	19307	0	0	0	0	0	193.07

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150011

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

Worksheet B  
Part I  
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Cost Center Description			HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			9.00	10.00	13.00	14.00	15.00	
193.08	19308	MGH FMC CONVERSE	0	0	0	2,573	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	23,159	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	0	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07950	MOW	0	135,003	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	128,278	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	5,147	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	194.12
194.13	07962	LYONS	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	194.14
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)	3,360,812	1,287,230	1,811,383	1,029,310	8,455,244	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150011

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
6.01	00601	CAFETERIA			6.01
6.02	00602	CAFETERIA			6.02
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	18,642,809	0	18,642,809
31.00	03100	INTENSIVE CARE UNIT	6,170,877	0	6,170,877
40.00	04000	SUBPROVIDER - IPF	0	0	0
41.00	04100	SUBPROVIDER - IRF	3,878,553	0	3,878,553
42.00	04200	SUBPROVIDER	0	0	0
43.00	04300	NURSERY	2,287,535	0	2,287,535
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	19,792,061	0	19,792,061
51.00	05100	RECOVERY ROOM	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,155,638	0	9,155,638
57.00	05700	CT SCAN	1,434,915	0	1,434,915
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	841,866	0	841,866
59.00	05900	CARDIAC CATHETERIZATION	3,532,335	0	3,532,335
60.00	06000	LABORATORY	10,909,128	0	10,909,128
60.01	06001	ONCOLOGY	2,399,034	0	2,399,034
60.02	06002	RADIATION ONCOLOGY	0	0	0
65.00	06500	RESPIRATORY THERAPY	3,710,173	0	3,710,173
66.00	06600	PHYSICAL THERAPY	3,635,901	0	3,635,901
69.00	06900	ELECTROCARDIOLOGY	2,364,213	0	2,364,213
69.01	06901	CARDIAC REHAB	458,090	0	458,090
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	13,346,376	0	13,346,376
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	1,011,780	0	1,011,780
91.00	09100	EMERGENCY	10,219,054	0	10,219,054
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	2,532,853	0	2,532,853
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	116,323,191	0	116,323,191
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	195,061	0	195,061
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0
192.02	19202	VISITOR MEALS	71,679	0	71,679
192.03	19203	GREAT BEGINNINGS/MATERNAL	199,948	0	199,948
192.04	19204	LIFELINE	0	0	0
192.05	19205	OWNED PROPERTIES	290,636	0	290,636
192.08	19211	PARISH NURSING	129,558	0	129,558
192.09	19212	BIOTERRORISM GRANT	84,758	0	84,758
192.10	19214	BREAST PUMPS	0	0	0
192.12	19209	LUNG CENTER	729,634	0	729,634
192.14	19210	MGH PHYS PRACT MGMT	2,316,519	0	2,316,519
192.15	19215	MGH MARION SURGEONS	3,198,874	0	3,198,874
192.16	19216	MGH MGH MED ONC	1,579,275	0	1,579,275
192.17	19217	MGH FMC SOUTH	4,295,289	0	4,295,289
192.18	19218	MGH FAIRM MED ASSOC	100,793	0	100,793
192.19	19219	MGH FMC MARION	1,024,855	0	1,024,855
193.00	19300	NONPAID WORKERS	0	0	0
193.01	19301	MGH FMC NORTHWOOD	1,326,486	0	1,326,486
193.02	19302	MGH FMC GAS CITY	743,198	0	743,198
193.03	19303	MGH HOSPITALISTS	3,713,912	0	3,713,912
193.04	19304	MGH MAR FAM PRACT	3,827,099	0	3,827,099
193.05	19305	MGH FMC SWAYZEE	303,909	0	303,909

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150011

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
193.06	19306	MGH PEDIATRIC CTR	1,711,699	0	1,711,699	193.06
193.07	19307	MGH SPECIALTY PHYS	465,635	0	465,635	193.07
193.08	19308	MGH FMC CONVERSE	416,977	0	416,977	193.08
193.09	19309	MGH UPLAND HEALTH	1,956,010	0	1,956,010	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	193.11
193.12	19312	OB/GYN	2,915,169	0	2,915,169	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	194.00
194.01	07950	MOW	135,003	0	135,003	194.01
194.02	07951	MENTAL HEALTH	128,278	0	128,278	194.02
194.03	07952	ADVERTISING	510,933	0	510,933	194.03
194.04	07953	MGH WORK SOLUTIONS	1,100,198	0	1,100,198	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	210,297	0	210,297	194.05
194.08	07957	MGH SMMP BLDG	349,890	0	349,890	194.08
194.09	07958	MGH AMBUCARE BLDG	64,529	0	64,529	194.09
194.10	07959	MGH 106 LYONS BLDG	5,685	0	5,685	194.10
194.11	07960	FAIRMOUNT	18,007	0	18,007	194.11
194.12	07961	GAS CITY	68,907	0	68,907	194.12
194.13	07962	LYONS	19,381	0	19,381	194.13
194.14	07964	WABASH	598	0	598	194.14
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	150,531,870	0	150,531,870	202.00



COST ALLOCATION STATISTICS

Provider CCN: 150011

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

Worksheet Non-CMS W  
Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1		1.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S		4.00
5.00	ADMINISTRATIVE & GENERAL	-73		5.00
6.00	MAINTENANCE & REPAIRS	1		6.00
6.01	CAFETERIA	71		6.01
6.02	CAFETERIA	72		6.02
7.00	OPERATION OF PLANT	1		7.00
8.00	LAUNDRY & LINEN SERVICE	8		8.00
9.00	HOUSEKEEPING	9		9.00
10.00	DIETARY	10		10.00
13.00	NURSING ADMINISTRATION	13		13.00
14.00	CENTRAL SERVICES & SUPPLY	14		14.00
15.00	PHARMACY	15		15.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150011

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

Worksheet B  
Part II  
Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	434,169	434,169	434,169		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	1,888,255	1,888,255	78,632	1,966,887	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
6.01 00601	CAFETERIA	0	150,926	150,926	0	24,776	6.01
6.02 00602	CAFETERIA	0	0	0	0	0	6.02
7.00 00700	OPERATION OF PLANT	0	2,940,088	2,940,088	5,638	132,101	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	65,894	65,894	0	8,280	8.00
9.00 00900	HOUSEKEEPING	0	102,300	102,300	0	41,536	9.00
10.00 01000	DIETARY	0	208,590	208,590	0	11,431	10.00
13.00 01300	NURSING ADMINISTRATION	0	21,819	21,819	8,829	22,641	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	74,310	74,310	1,527	10,586	14.00
15.00 01500	PHARMACY	0	95,225	95,225	23,016	106,735	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	0	1,346,612	1,346,612	63,630	179,018	30.00
31.00 03100	INTENSIVE CARE UNIT	0	312,013	312,013	22,801	63,751	31.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF	0	298,766	298,766	9,431	38,124	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	9,191	28,479	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	0	1,077,863	1,077,863	0	217,537	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	644,785	644,785	22,882	100,684	54.00
57.00 05700	CT SCAN	0	47,410	47,410	4,124	17,058	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	55,607	55,607	2,154	9,609	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	157,097	157,097	5,107	40,382	59.00
60.00 06000	LABORATORY	0	397,170	397,170	21,964	129,171	60.00
60.01 06001	ONCOLOGY	0	0	0	9,264	31,312	60.01
60.02 06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00 06500	RESPIRATORY THERAPY	0	143,164	143,164	11,969	41,045	65.00
66.00 06600	PHYSICAL THERAPY	0	27,461	27,461	17,282	45,341	66.00
69.00 06900	ELECTROCARDIOLOGY	0	247,927	247,927	7,232	22,721	69.00
69.01 06901	CARDIAC REHAB	0	40,428	40,428	1,195	3,756	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	63,908	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000	CLINIC	0	88,274	88,274	2,727	10,089	90.00
91.00 09100	EMERGENCY	0	345,552	345,552	37,855	106,985	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00 09500	AMBULANCE SERVICES	0	129,450	129,450	10,193	27,104	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	11,341,155	11,341,155	376,643	1,534,160	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	41,986	41,986	254	1,528	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02 19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03 19203	GREAT BEGINNINGS/MATERNAL	0	0	0	1,036	2,500	192.03
192.04 19204	LIFELINE	0	0	0	0	0	192.04
192.05 19205	OWNED PROPERTIES	0	0	0	0	1,402	192.05
192.08 19211	PARISH NURSING	0	10,660	10,660	377	1,351	192.08
192.09 19212	BIO-TERRORISM GRANT	0	0	0	297	1,107	192.09
192.10 19214	BREAST PUMPS	0	0	0	0	0	192.10
192.12 19209	LUNG CENTER	0	0	0	984	9,417	192.12
192.14 19210	MGH PHYS PRACT MGMT	0	0	0	8,995	29,142	192.14
192.15 19215	MGH MARION SURGEONS	0	0	0	4,492	40,954	192.15
192.16 19216	MGH MGH MED ONC	0	0	0	4	20,635	192.16
192.17 19217	MGH FMC SOUTH	0	0	0	7,576	54,355	192.17
192.18 19218	MGH FAIRMED ASSOC	0	0	0	53	1,317	192.18
192.19 19219	MGH FMC MARION	0	0	0	2,191	12,872	192.19
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301	MGH FMC NORTHWOOD	0	0	0	2,709	17,298	193.01
193.02 19302	MGH FMC GAS CITY	0	0	0	1,484	9,509	193.02
193.03 19303	MGH HOSPITALISTS	0	0	0	723	48,526	193.03
193.04 19304	MGH MARFAM PRACT	0	0	0	7,275	49,602	193.04

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150011

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

Worksheet B  
Part II  
Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
193.05 19305 MGH FMC SWAYZEE	0	0	0	0	711	3,937	193.05
193.06 19306 MGH PEDIATRIC CTR	0	0	0	0	2,620	22,021	193.06
193.07 19307 MGH SPECIALTY PHYS	0	0	0	0	752	6,008	193.07
193.08 19308 MGH FMC CONVERSE	0	0	0	0	1,054	5,415	193.08
193.09 19309 MGH UPLAND HEALTH	0	0	0	0	3,549	25,255	193.09
193.10 19310 MGH MGH WOMENS CTR	0	0	0	0	0	0	193.10
193.11 19311 MGH MGH PSYCHIATRY	0	0	0	0	0	0	193.11
193.12 19312 OB/GYN	0	0	0	0	4,202	38,090	193.12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0	0	0	193.15
194.00 07963 OTHER NONREIMBURSABLE	0	0	0	0	0	0	194.00
194.01 07950 MOW	0	0	0	0	0	0	194.01
194.02 07951 MENTAL HEALTH	0	0	0	0	0	0	194.02
194.03 07952 ADVERTISING	0	0	0	0	2,167	6,545	194.03
194.04 07953 MGH WORK SOLUTIONS	0	0	0	0	3,519	14,308	194.04
194.05 07954 MGH TAYLOR UNIVERSITY	0	0	0	0	502	2,748	194.05
194.08 07957 MGH SMMP BLDG	0	0	0	0	0	4,572	194.08
194.09 07958 MGH AMBUCARE BLDG	0	0	0	0	0	843	194.09
194.10 07959 MGH 106 LYONS BLDG	0	0	0	0	0	74	194.10
194.11 07960 FAIRMOUNT	0	0	0	0	0	235	194.11
194.12 07961 GAS CITY	0	0	0	0	0	900	194.12
194.13 07962 LYONS	0	0	0	0	0	253	194.13
194.14 07964 WABASH	0	0	0	0	0	8	194.14
200.00 Cross Foot Adjustments				0			200.00
201.00 Negative Cost Centers			0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	11,393,801		11,393,801	434,169	1,966,887	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 11/23/2016 9:25 am			
Cost Center Description		MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		6.00	6.01	6.02	7.00	8.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
6.01	00601	CAFETERIA	0	175,702			6.01
6.02	00602	CAFETERIA	0	169,060	169,060		6.02
7.00	00700	OPERATION OF PLANT	0	0	4,087	3,081,914	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	33,958	108,132
9.00	00900	HOUSEKEEPING	0	0	0	52,719	1,189
10.00	01000	DIETARY	0	0	0	107,495	1,787
13.00	01300	NURSING ADMINISTRATION	0	0	2,519	11,244	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,199	38,295	1,218
15.00	01500	PHARMACY	0	0	7,310	49,073	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	0	30,460	693,961	25,784
31.00	03100	INTENSIVE CARE UNIT	0	0	10,198	160,792	6,638
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	4,609	153,966	3,535
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	4,017	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	21,011	555,465	15,075
51.00	05100	RECOVERY ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	11,547	332,283	9,665
57.00	05700	CT SCAN	0	0	2,139	24,432	2,495
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	1,117	28,657	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	2,499	80,958	2,861
60.00	06000	LABORATORY	0	0	11,732	204,677	0
60.01	06001	ONCOLOGY	0	0	0	0	0
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	5,154	73,778	396
66.00	06600	PHYSICAL THERAPY	0	0	3,512	14,152	3,599
69.00	06900	ELECTROCARDIOLOGY	0	0	3,973	127,767	698
69.01	06901	CARDIAC REHAB	0	0	595	20,834	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	1,121	45,491	340
91.00	09100	EMERGENCY	0	0	18,245	178,076	27,224
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	6,316	66,710	5,609
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	169,060	153,360	3,054,783	108,113
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	103	21,637	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.02	19202	VISITOR MEALS	0	6,642	0	0	0
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	0
192.04	19204	LIFELINE	0	0	0	0	0
192.05	19205	OWNED PROPERTIES	0	0	0	0	0
192.08	19211	PARISH NURSING	0	0	215	5,494	0
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0
192.10	19214	BREAST PUMPS	0	0	0	0	0
192.12	19209	LUNG CENTER	0	0	826	0	0
192.14	19210	MGH PHYS PRACT MGMT	0	0	5,860	0	0
192.15	19215	MGH MARION SURGEONS	0	0	3,255	0	0
192.16	19216	MGH MGH MED ONC	0	0	0	0	0
192.17	19217	MGH FMC SOUTH	0	0	0	0	19
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	0
192.19	19219	MGH FMC MARION	0	0	1,775	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	MGH FMC NORTHWOOD	0	0	0	0	0
193.02	19302	MGH FMC GAS CITY	0	0	0	0	0
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0
193.04	19304	MGH MAR FAM PRACT	0	0	0	0	0
193.05	19305	MGH FMC SWAYZEE	0	0	0	0	0
193.06	19306	MGH PEDIATRIC CTR	0	0	2,204	0	0
193.07	19307	MGH SPECIALTY PHYS	0	0	536	0	0
193.08	19308	MGH FMC CONVERSE	0	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150011

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

Worksheet B  
Part II  
Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description			MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			6.00	6.01	6.02	7.00	8.00	
193.09	19309	MGH UPLAND HEALTH	0	0	0	0	0	0
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	0
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	0
193.12	19312	OB/GYN	0	0	0	0	0	0
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	0
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	0	0
194.01	07950	MOW	0	0	0	0	0	0
194.02	07951	MENTAL HEALTH	0	0	0	0	0	0
194.03	07952	ADVERTISING	0	0	926	0	0	0
194.04	07953	MGH WORK SOLUTIONS	0	0	0	0	0	0
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	0
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	0
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	0
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	0
194.11	07960	FAIRMOUNT	0	0	0	0	0	0
194.12	07961	GAS CITY	0	0	0	0	0	0
194.13	07962	LYONS	0	0	0	0	0	0
194.14	07964	WABASH	0	0	0	0	0	0
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	0	175,702	169,060	3,081,914	108,132	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150011		Period: From 07/01/2015 To 06/30/2016		Worksheet B Part II Date/Time Prepared: 11/23/2016 9:25 am	
Cost Center Description		HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
6.01	00601 CAFETERIA						6.01
6.02	00602 CAFETERIA						6.02
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING	197,744					9.00
10.00	01000 DIETARY	2,697	332,000				10.00
13.00	01300 NURSING ADMINISTRATION			843	67,895		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY					131,349	14.00
15.00	01500 PHARMACY						15.00
		2,697		0	0	0	
						284,056	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	39,112	188,863	18,345	33,499	0	30.00
31.00	03100 INTENSIVE CARE UNIT	10,789	40,227	6,143	13,135	0	31.00
40.00	04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100 SUBPROVIDER - IRF	9,440	32,043	2,776	2,627	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300 NURSERY	0	0	2,420	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	27,647	0	12,656	22,526	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,429	0	0	2,627	0	54.00
57.00	05700 CT SCAN	506	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	3,372	0	1,505	3,940	0	59.00
60.00	06000 LABORATORY	9,440	0	0	7,881	0	60.00
60.01	06001 ONCOLOGY	0	0	0	328	0	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	7,080	0	3,391	7,224	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	2,115	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	4,552	0	2,393	1,970	0	69.00
69.01	06901 CARDIAC REHAB	5,057	0	359	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	284,056	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	3,372	0	675	0	0	90.00
91.00	09100 EMERGENCY	37,762	2,962	10,990	14,448	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	1,180	0	3,804	1,313	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	178,189	264,095	67,572	111,518	284,056	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	337	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202 VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203 GREAT BEGINNINGS/MATERNAL	0	0	323	0	0	192.03
192.04	19204 LIFELINE	0	0	0	0	0	192.04
192.05	19205 OWNED PROPERTIES	10,789	0	0	0	0	192.05
192.08	19211 PARISH NURSING	337	0	0	0	0	192.08
192.09	19212 BIOTERRORISM GRANT	0	0	0	0	0	192.09
192.10	19214 BREAST PUMPS	0	0	0	0	0	192.10
192.12	19209 LUNG CENTER	0	0	0	0	0	192.12
192.14	19210 MGH PHYS PRACT MGMT	1,349	0	0	0	0	192.14
192.15	19215 MGH MARION SURGEONS	0	0	0	3,743	0	192.15
192.16	19216 MGH MGH MED ONC	0	0	0	0	0	192.16
192.17	19217 MGH FMC SOUTH	6,743	0	0	2,627	0	192.17
192.18	19218 MGH FAIRM MED ASSOC	0	0	0	0	0	192.18
192.19	19219 MGH FMC MARION	0	0	0	2,627	0	192.19
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301 MGH FMC NORTHWOOD	0	0	0	328	0	193.01
193.02	19302 MGH FMC GAS CITY	0	0	0	1,970	0	193.02
193.03	19303 MGH HOSPITALISTS	0	0	0	0	0	193.03
193.04	19304 MGH MAR FAM PRACT	0	0	0	3,940	0	193.04
193.05	19305 MGH FMC SWAYZEE	0	0	0	328	0	193.05
193.06	19306 MGH PEDIATRIC CTR	0	0	0	328	0	193.06
193.07	19307 MGH SPECIALTY PHYS	0	0	0	0	0	193.07

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150011

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

Worksheet B  
Part II  
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11/23/2016 9:25 am

Cost Center Description	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	9.00	10.00	13.00	14.00	15.00	
193.08 19308 MGH FMC CONVERSE	0	0	0	328	0	193.08
193.09 19309 MGH UPLAND HEALTH	0	0	0	2,955	0	193.09
193.10 19310 MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11 19311 MGH MGH PSYCHIATRY	0	0	0	0	0	193.11
193.12 19312 OB/GYN	0	0	0	0	0	193.12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00 07963 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01 07950 MOW	0	34,820	0	0	0	194.01
194.02 07951 MENTAL HEALTH	0	33,085	0	0	0	194.02
194.03 07952 ADVERTISING	0	0	0	0	0	194.03
194.04 07953 MGH WORK SOLUTIONS	0	0	0	657	0	194.04
194.05 07954 MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.08 07957 MGH SMMP BLDG	0	0	0	0	0	194.08
194.09 07958 MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10 07959 MGH 106 LYONS BLDG	0	0	0	0	0	194.10
194.11 07960 FAIRMOUNT	0	0	0	0	0	194.11
194.12 07961 GAS CITY	0	0	0	0	0	194.12
194.13 07962 LYONS	0	0	0	0	0	194.13
194.14 07964 WABASH	0	0	0	0	0	194.14
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)	197,744	332,000	67,895	131,349	284,056	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150011

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

Worksheet B  
Part II  
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
6.01	00601				6.01
6.02	00602				6.02
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	2,619,284	0	2,619,284	30.00
31.00	03100	646,487	0	646,487	31.00
40.00	04000	0	0	0	40.00
41.00	04100	555,317	0	555,317	41.00
42.00	04200	0	0	0	42.00
43.00	04300	44,107	0	44,107	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	1,949,780	0	1,949,780	50.00
51.00	05100	0	0	0	51.00
54.00	05400	1,132,902	0	1,132,902	54.00
57.00	05700	98,164	0	98,164	57.00
58.00	05800	97,144	0	97,144	58.00
59.00	05900	297,721	0	297,721	59.00
60.00	06000	782,035	0	782,035	60.00
60.01	06001	40,904	0	40,904	60.01
60.02	06002	0	0	0	60.02
65.00	06500	293,201	0	293,201	65.00
66.00	06600	113,462	0	113,462	66.00
69.00	06900	419,233	0	419,233	69.00
69.01	06901	72,224	0	72,224	69.01
71.00	07100	0	0	0	71.00
72.00	07200	0	0	0	72.00
73.00	07300	347,964	0	347,964	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	152,089	0	152,089	90.00
91.00	09100	780,099	0	780,099	91.00
92.00	09200	0	0	0	92.00
92.01	09201	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	251,679	0	251,679	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	0	0	0	113.00
118.00		10,693,796	0	10,693,796	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	65,845	0	65,845	190.00
192.00	19200	0	0	0	192.00
192.02	19202	6,642	0	6,642	192.02
192.03	19203	3,859	0	3,859	192.03
192.04	19204	0	0	0	192.04
192.05	19205	12,191	0	12,191	192.05
192.08	19211	18,434	0	18,434	192.08
192.09	19212	1,404	0	1,404	192.09
192.10	19214	0	0	0	192.10
192.12	19209	11,227	0	11,227	192.12
192.14	19210	45,346	0	45,346	192.14
192.15	19215	52,444	0	52,444	192.15
192.16	19216	20,639	0	20,639	192.16
192.17	19217	71,320	0	71,320	192.17
192.18	19218	1,370	0	1,370	192.18
192.19	19219	19,465	0	19,465	192.19
193.00	19300	0	0	0	193.00
193.01	19301	20,335	0	20,335	193.01
193.02	19302	12,963	0	12,963	193.02
193.03	19303	49,249	0	49,249	193.03
193.04	19304	60,817	0	60,817	193.04
193.05	19305	4,976	0	4,976	193.05



ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150011

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

Worksheet B  
Part II  
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
193.06	19306	MGH PEDIATRIC CTR	27,173	0	27,173	193.06
193.07	19307	MGH SPECIALTY PHYS	7,296	0	7,296	193.07
193.08	19308	MGH FMC CONVERSE	6,797	0	6,797	193.08
193.09	19309	MGH UPLAND HEALTH	31,759	0	31,759	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	193.11
193.12	19312	OB/GYN	42,292	0	42,292	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	194.00
194.01	07950	MOW	34,820	0	34,820	194.01
194.02	07951	MENTAL HEALTH	33,085	0	33,085	194.02
194.03	07952	ADVERTISING	9,638	0	9,638	194.03
194.04	07953	MGH WORK SOLUTIONS	18,484	0	18,484	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	3,250	0	3,250	194.05
194.08	07957	MGH SMMP BLDG	4,572	0	4,572	194.08
194.09	07958	MGH AMBUCARE BLDG	843	0	843	194.09
194.10	07959	MGH 106 LYONS BLDG	74	0	74	194.10
194.11	07960	FAIRMOUNT	235	0	235	194.11
194.12	07961	GAS CITY	900	0	900	194.12
194.13	07962	LYONS	253	0	253	194.13
194.14	07964	WABASH	8	0	8	194.14
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	11,393,801	0	11,393,801	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150011

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

Worksheet B-1

Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5A	5.00	6.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	365,536				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	13,929	44,686,220			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	60,579	8,093,528	-25,865,262	124,666,608	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
6.01 00601	CAFETERIA	4,842	0	0	1,570,401	6.01
6.02 00602	CAFETERIA	0	0	0	0	6.02
7.00 00700	OPERATION OF PLANT	94,324	580,291	0	8,372,987	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	2,114	0	0	524,809	8.00
9.00 00900	HOUSEKEEPING	3,282	0	0	2,632,694	9.00
10.00 01000	DIETARY	6,692	0	0	724,565	10.00
13.00 01300	NURSING ADMINISTRATION	700	908,685	0	1,435,080	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,384	157,130	0	670,967	14.00
15.00 01500	PHARMACY	3,055	2,368,844	0	6,765,209	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	43,202	6,548,941	0	11,346,779	30.00
31.00 03100	INTENSIVE CARE UNIT	10,010	2,346,724	0	4,040,767	31.00
40.00 04000	SUBPROVIDER - I/PF	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - I/RF	9,585	970,710	0	2,416,459	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	0	945,953	0	1,805,104	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	34,580	0	0	13,786,713	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	20,686	2,355,116	0	6,381,691	54.00
57.00 05700	CT SCAN	1,521	424,497	0	1,081,205	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,784	221,675	0	609,031	58.00
59.00 05900	CARDIAC CATHETERIZATION	5,040	525,640	0	2,559,524	59.00
60.00 06000	LABORATORY	12,742	2,260,597	0	8,187,280	60.00
60.01 06001	ONCOLOGY	0	953,435	0	1,984,688	60.01
60.02 06002	RADIATION ONCOLOGY	0	0	0	0	60.02
65.00 06500	RESPIRATORY THERAPY	4,593	1,231,891	0	2,601,567	65.00
66.00 06600	PHYSICAL THERAPY	881	1,778,724	0	2,873,864	66.00
69.00 06900	ELECTROCARDIOLOGY	7,954	744,364	0	1,440,124	69.00
69.01 06901	CARDIAC REHAB	1,297	122,960	0	238,098	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,050,711	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	2,832	280,644	0	639,473	90.00
91.00 09100	EMERGENCY	11,086	3,896,201	0	6,781,098	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	4,153	1,049,119	0	1,717,952	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	363,847	38,765,669	-25,865,262	97,238,840	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,347	26,176	0	96,835	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.02 19202	VISITOR MEALS	0	0	0	0	192.02
192.03 19203	GREAT BEGINNINGS/MATERNAL	0	106,583	0	158,445	192.03
192.04 19204	LIFELINE	0	0	0	0	192.04
192.05 19205	OWNED PROPERTIES	0	0	0	88,836	192.05
192.08 19211	PARIISH NURSING	342	38,800	0	85,641	192.08
192.09 19212	BIOTERRORISM GRANT	0	30,566	0	70,194	192.09
192.10 19214	BREAST PUMPS	0	0	0	0	192.10
192.12 19209	LUNG CENTER	0	101,226	0	596,883	192.12
192.14 19210	MGH PHYS PRACT MGMT	0	925,815	0	1,847,120	192.14
192.15 19215	MGH MARION SURGEONS	0	462,295	0	2,595,834	192.15
192.16 19216	MGH MGH MED ONC	0	414	0	1,307,915	192.16
192.17 19217	MGH FMC SOUTH	0	779,720	0	3,445,179	192.17
192.18 19218	MGH FAIRM MED ASSOC	0	5,416	0	83,474	192.18
192.19 19219	MGH FMC MARION	0	225,516	0	815,846	192.19
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
193.01 19301	MGH FMC NORTHWOOD	0	278,780	0	1,096,431	193.01
193.02 19302	MGH FMC GAS CITY	0	152,745	0	602,711	193.02
193.03 19303	MGH HOSPITALISTS	0	74,369	0	3,075,767	193.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150011

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

Worksheet B-1

Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00	4.00		5A	5.00	6.00	
193.04 19304 MGH MAR FAM PRACT	0	748,746		0	3,143,933		0 193.04
193.05 19305 MGH FMC SWAYZEE	0	73,226		0	249,559		0 193.05
193.06 19306 MGH PEDIATRIC CTR	0	269,618		0	1,395,755		0 193.06
193.07 19307 MGH SPECIALTY PHYS	0	77,416		0	380,834		0 193.07
193.08 19308 MGH FMC CONVERSE	0	108,440		0	343,199		0 193.08
193.09 19309 MGH UPLAND HEALTH	0	365,258		0	1,600,738		0 193.09
193.10 19310 MGH MGH WOMENS CTR	0	0		0	0		0 193.10
193.11 19311 MGH MGH PSYCHIATRY	0	0		0	0		0 193.11
193.12 19312 OB/GYN	0	432,487		0	2,414,269		0 193.12
193.15 19315 MGH RIVER VIEW BLDG	0	0		0	0		0 193.15
194.00 07963 OTHER NONREIMBURSABLE	0	0		0	0		0 194.00
194.01 07950 MOW	0	0		0	0		0 194.01
194.02 07951 MENTAL HEALTH	0	0		0	0		0 194.02
194.03 07952 ADVERTISING	0	223,044		0	414,869		0 194.03
194.04 07953 MGH WORK SOLUTIONS	0	362,216		0	906,893		0 194.04
194.05 07954 MGH TAYLOR UNIVERSITY	0	51,679		0	174,163		0 194.05
194.08 07957 MGH SMMP BLDG	0	0		0	289,770		0 194.08
194.09 07958 MGH AMBUCARE BLDG	0	0		0	53,441		0 194.09
194.10 07959 MGH 106 LYONS BLDG	0	0		0	4,708		0 194.10
194.11 07960 FAIRMOUNT	0	0		0	14,913		0 194.11
194.12 07961 GAS CITY	0	0		0	57,067		0 194.12
194.13 07962 LYONS	0	0		0	16,051		0 194.13
194.14 07964 WABASH	0	0		0	495		0 194.14
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)	11,393,801	20,046,275			25,865,262		0 202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	31.170120	0.448601			0.207475	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)		434,169			1,966,887		0 204.00
205.00 Unit cost multiplier (Wkst. B, Part II)		0.009716			0.015777	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150011

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

Worksheet B-1

Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description		CAFETERIA (MEALS SERVED)	CAFETERIA (HOURS WORKED)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		6.01	6.02	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
6.01	00601	266,158					6.01
6.02	00602	256,097	1,361,119				6.02
7.00	00700		32,905	191,862			7.00
8.00	00800			2,114	824,517		8.00
9.00	00900			3,282	9,068	60,996	9.00
10.00	01000			6,692	13,624	832	10.00
13.00	01300		20,282	700		260	13.00
14.00	01400		9,650	2,384	9,285	1,300	14.00
15.00	01500		58,856	3,055		832	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000		245,223	43,202	196,605	12,064	30.00
31.00	03100		82,106	10,010	50,612	3,328	31.00
40.00	04000						40.00
41.00	04100		37,107	9,585	26,958	2,912	41.00
42.00	04200						42.00
43.00	04300		32,345				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000		169,162	34,580	114,946	8,528	50.00
51.00	05100						51.00
54.00	05400		92,966	20,686	73,696	2,600	54.00
57.00	05700		17,225	1,521	19,024	156	57.00
58.00	05800		8,995	1,784			58.00
59.00	05900		20,118	5,040	21,817	1,040	59.00
60.00	06000		94,456	12,742		2,912	60.00
60.01	06001						60.01
60.02	06002						60.02
65.00	06500		41,493	4,593	3,021	2,184	65.00
66.00	06600		28,276	881	27,442		66.00
69.00	06900		31,988	7,954	5,319	1,404	69.00
69.01	06901		4,794	1,297		1,560	69.01
71.00	07100						71.00
72.00	07200						72.00
73.00	07300						73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000		9,023	2,832	2,590	1,040	90.00
91.00	09100		146,894	11,086	207,596	11,648	91.00
92.00	09200						92.00
92.01	09201						92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500		50,847	4,153	42,771	364	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00							118.00
		256,097	1,234,711	190,173	824,374	54,964	
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000		832	1,347		104	190.00
192.00	19200						192.00
192.02	19202	10,061					192.02
192.03	19203						192.03
192.04	19204						192.04
192.05	19205					3,328	192.05
192.08	19211		1,730	342		104	192.08
192.09	19212						192.09
192.10	19214						192.10
192.12	19209		6,649				192.12
192.14	19210		47,183			416	192.14
192.15	19215		26,210				192.15
192.16	19216						192.16
192.17	19217				143	2,080	192.17
192.18	19218						192.18
192.19	19219		14,290				192.19
193.00	19300						193.00
193.01	19301						193.01
193.02	19302						193.02
193.03	19303						193.03
193.04	19304						193.04
193.05	19305						193.05
193.06	19306		17,745				193.06

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150011

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

Worksheet B-1

Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description			CAFETERIA (MEALS SERVED)	CAFETERIA (HOURS WORKED)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)		
			6.01	6.02	7.00	8.00	9.00		
193.07	19307	MGH SPECIALTY PHYS	0	4,317	0	0	0	0	193.07
193.08	19308	MGH FMC CONVERSE	0	0	0	0	0	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	0	0	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	0	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	0	0	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	7,452	0	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	0	0	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	0	194.10
194.11	07960	FAIRMOUNT	0	0	0	0	0	0	194.11
194.12	07961	GAS CITY	0	0	0	0	0	0	194.12
194.13	07962	LYONS	0	0	0	0	0	0	194.13
194.14	07964	WABASH	0	0	0	0	0	0	194.14
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)	1,896,220	1,824,541	10,154,280	745,577	3,360,812		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.124415	1.340471	52.924915	0.904259	55.098892		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	175,702	169,060	3,081,914	108,132	197,744		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.660142	0.124207	16.063181	0.131146	3.241918		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150011

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

Worksheet B-1

Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description		DIETARY (MEALS SERVED)	NURSING ADMINISTRATION  (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)		
		10.00	13.00	14.00	15.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
6.01	00601						6.01
6.02	00602						6.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	91,115					10.00
13.00	01300	0	907,530				13.00
14.00	01400	0	0	10,000			14.00
15.00	01500	0	0	0	100		15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	51,832	245,223	2,550	0		30.00
31.00	03100	11,040	82,106	1,000	0		31.00
40.00	04000	0	0	0	0		40.00
41.00	04100	8,794	37,107	200	0		41.00
42.00	04200	0	0	0	0		42.00
43.00	04300	0	32,345	0	0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	169,162	1,715	0		50.00
51.00	05100	0	0	0	0		51.00
54.00	05400	0	0	200	0		54.00
57.00	05700	0	0	0	0		57.00
58.00	05800	0	0	0	0		58.00
59.00	05900	0	20,118	300	0		59.00
60.00	06000	0	0	600	0		60.00
60.01	06001	0	0	25	0		60.01
60.02	06002	0	0	0	0		60.02
65.00	06500	0	45,323	550	0		65.00
66.00	06600	0	28,276	0	0		66.00
69.00	06900	0	31,988	150	0		69.00
69.01	06901	0	4,794	0	0		69.01
71.00	07100	0	0	0	0		71.00
72.00	07200	0	0	0	0		72.00
73.00	07300	0	0	0	100		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	9,023	0	0		90.00
91.00	09100	813	146,894	1,100	0		91.00
92.00	09200	0	0	0	0		92.00
92.01	09201	0	0	0	0		92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	50,847	100	0		95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	0	0	0	0		113.00
118.00		72,479	903,206	8,490	100		118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0		190.00
192.00	19200	0	0	0	0		192.00
192.02	19202	0	0	0	0		192.02
192.03	19203	0	4,324	0	0		192.03
192.04	19204	0	0	0	0		192.04
192.05	19205	0	0	0	0		192.05
192.08	19211	0	0	0	0		192.08
192.09	19212	0	0	0	0		192.09
192.10	19214	0	0	0	0		192.10
192.12	19209	0	0	0	0		192.12
192.14	19210	0	0	0	0		192.14
192.15	19215	0	0	285	0		192.15
192.16	19216	0	0	0	0		192.16
192.17	19217	0	0	200	0		192.17
192.18	19218	0	0	0	0		192.18
192.19	19219	0	0	200	0		192.19
193.00	19300	0	0	0	0		193.00
193.01	19301	0	0	25	0		193.01
193.02	19302	0	0	150	0		193.02
193.03	19303	0	0	0	0		193.03
193.04	19304	0	0	300	0		193.04
193.05	19305	0	0	25	0		193.05

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150011

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

Worksheet B-1

Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description		DIETARY (MEALS SERVED)	NURSING ADMINISTRATION  (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)		
		10.00	13.00	14.00	15.00		
193.06	19306	0	0	25	0		193.06
193.07	19307	0	0	0	0		193.07
193.08	19308	0	0	25	0		193.08
193.09	19309	0	0	225	0		193.09
193.10	19310	0	0	0	0		193.10
193.11	19311	0	0	0	0		193.11
193.12	19312	0	0	0	0		193.12
193.15	19315	0	0	0	0		193.15
194.00	07963	0	0	0	0		194.00
194.01	07950	9,556	0	0	0		194.01
194.02	07951	9,080	0	0	0		194.02
194.03	07952	0	0	0	0		194.03
194.04	07953	0	0	50	0		194.04
194.05	07954	0	0	0	0		194.05
194.08	07957	0	0	0	0		194.08
194.09	07958	0	0	0	0		194.09
194.10	07959	0	0	0	0		194.10
194.11	07960	0	0	0	0		194.11
194.12	07961	0	0	0	0		194.12
194.13	07962	0	0	0	0		194.13
194.14	07964	0	0	0	0		194.14
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)	1,287,230	1,811,383	1,029,310	8,455,244		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	14.127531	1.995948	102.931000	84,552.440000		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	332,000	67,895	131,349	284,056		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.643747	0.074813	13.134900	2,840.560000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/23/2016 9:25 am
		Title XVII	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		18,642,809	0	18,642,809	30.00
31.00	03100 INTENSIVE CARE UNIT		6,170,877	0	6,170,877	31.00
40.00	04000 SUBPROVIDER - I/PF		0	0	0	40.00
41.00	04100 SUBPROVIDER - I/RP		3,878,553	0	3,878,553	41.00
42.00	04200 SUBPROVIDER		0	0	0	42.00
43.00	04300 NURSERY		2,287,535	0	2,287,535	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		19,792,061	0	19,792,061	50.00
51.00	05100 RECOVERY ROOM		0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		9,155,638	0	9,155,638	54.00
57.00	05700 CT SCAN		1,434,915	0	1,434,915	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		841,866	0	841,866	58.00
59.00	05900 CARDIAC CATHETERIZATION		3,532,335	0	3,532,335	59.00
60.00	06000 LABORATORY		10,909,128	0	10,909,128	60.00
60.01	06001 ONCOLOGY		2,399,034	0	2,399,034	60.01
60.02	06002 RADIATION ONCOLOGY		0	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0	3,710,173	0	3,710,173	65.00
66.00	06600 PHYSICAL THERAPY	0	3,635,901	0	3,635,901	66.00
69.00	06900 ELECTROCARDIOLOGY		2,364,213	0	2,364,213	69.00
69.01	06901 CARDIAC REHAB		458,090	0	458,090	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		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		13,346,376	0	13,346,376	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC		1,011,780	0	1,011,780	90.00
91.00	09100 EMERGENCY		10,219,054	0	10,219,054	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		3,226,979	0	3,226,979	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)		0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES		2,532,853	0	2,532,853	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		119,550,170	0	119,550,170	200.00
201.00	Less Observation Beds		3,226,979	0	3,226,979	201.00
202.00	Total (see instructions)		116,323,191	0	116,323,191	202.00



COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150011

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/23/2016 9:25 am

		Title XVII I			Hospital	PPS	
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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	17,462,687		17,462,687		30.00
31.00	03100	INTENSIVE CARE UNIT	8,753,414		8,753,414		31.00
40.00	04000	SUBPROVIDER - I PF	0		0		40.00
41.00	04100	SUBPROVIDER - I RF	4,012,478		4,012,478		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	2,402,568		2,402,568		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	37,191,178	63,747,604	100,938,782	0.196080	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,655,775	24,405,386	26,061,161	0.351314	54.00
57.00	05700	CT SCAN	4,313,849	26,639,679	30,953,528	0.046357	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	333,297	3,277,223	3,610,520	0.233170	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,013,460	6,055,655	9,069,115	0.389491	59.00
60.00	06000	LABORATORY	2,834,336	10,247,307	13,081,643	0.833926	60.00
60.01	06001	ONCOLOGY	34,063	5,823,164	5,857,227	0.409585	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0.000000	60.02
65.00	06500	RESPIRATORY THERAPY	2,879,815	5,155,711	8,035,526	0.461721	65.00
66.00	06600	PHYSICAL THERAPY	5,795,905	4,401,796	10,197,701	0.356541	66.00
69.00	06900	ELECTROCARDIOLOGY	3,597,945	6,081,701	9,679,646	0.244246	69.00
69.01	06901	CARDIAC REHAB	0	777,186	777,186	0.589421	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,633,880	57,633,386	65,267,266	0.204488	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	629,837	629,837	1.606416	90.00
91.00	09100	EMERGENCY	9,779,991	57,182,777	66,962,768	0.152608	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	333,842	5,051,958	5,385,800	0.599164	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	4,339,127	4,339,127	0.583724	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	112,028,483	281,449,497	393,477,980		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	112,028,483	281,449,497	393,477,980		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150011

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
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
42.00	04200 SUBPROVIDER				42.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.196080			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.351314			54.00
57.00	05700 CT SCAN	0.046357			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.233170			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.389491			59.00
60.00	06000 LABORATORY	0.833926			60.00
60.01	06001 ONCOLOGY	0.409585			60.01
60.02	06002 RADIATION ONCOLOGY	0.000000			60.02
65.00	06500 RESPIRATORY THERAPY	0.461721			65.00
66.00	06600 PHYSICAL THERAPY	0.356541			66.00
69.00	06900 ELECTROCARDIOLOGY	0.244246			69.00
69.01	06901 CARDIAC REHAB	0.589421			69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.204488			73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	1.606416			90.00
91.00	09100 EMERGENCY	0.152608			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.599164			92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000			92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES	0.583724			95.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150011

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/23/2016 9:25 am

		Title XIX		Hospital		Cost		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs		
				Total Costs	RCE Disallowance			
		1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	18,642,809		18,642,809	0	18,642,809	30.00
31.00	03100	INTENSIVE CARE UNIT	6,170,877		6,170,877	0	6,170,877	31.00
40.00	04000	SUBPROVIDER - I/PF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - I/RF	3,878,553		3,878,553	0	3,878,553	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	2,287,535		2,287,535	0	2,287,535	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	19,792,061		19,792,061	0	19,792,061	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,155,638		9,155,638	0	9,155,638	54.00
57.00	05700	CT SCAN	1,434,915		1,434,915	0	1,434,915	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	841,866		841,866	0	841,866	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,532,335		3,532,335	0	3,532,335	59.00
60.00	06000	LABORATORY	10,909,128		10,909,128	0	10,909,128	60.00
60.01	06001	ONCOLOGY	2,399,034		2,399,034	0	2,399,034	60.01
60.02	06002	RADIATION ONCOLOGY	0		0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	3,710,173	0	3,710,173	0	3,710,173	65.00
66.00	06600	PHYSICAL THERAPY	3,635,901	0	3,635,901	0	3,635,901	66.00
69.00	06900	ELECTROCARDIOLOGY	2,364,213		2,364,213	0	2,364,213	69.00
69.01	06901	CARDIAC REHAB	458,090		458,090	0	458,090	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,346,376		13,346,376	0	13,346,376	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	1,011,780		1,011,780	0	1,011,780	90.00
91.00	09100	EMERGENCY	10,219,054		10,219,054	0	10,219,054	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,226,979		3,226,979	0	3,226,979	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	2,532,853		2,532,853	0	2,532,853	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	119,550,170	0	119,550,170	0	119,550,170	200.00
201.00		Less Observation Beds	3,226,979		3,226,979		3,226,979	201.00
202.00		Total (see instructions)	116,323,191	0	116,323,191	0	116,323,191	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150011

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/23/2016 9:25 am

		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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	17,462,687		17,462,687		30.00
31.00	03100	INTENSIVE CARE UNIT	8,753,414		8,753,414		31.00
40.00	04000	SUBPROVIDER - I/PF	0		0		40.00
41.00	04100	SUBPROVIDER - I/RP	4,012,478		4,012,478		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	2,402,568		2,402,568		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	37,191,178	63,747,604	100,938,782	0.196080	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,655,775	24,405,386	26,061,161	0.351314	54.00
57.00	05700	CT SCAN	4,313,849	26,639,679	30,953,528	0.046357	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	333,297	3,277,223	3,610,520	0.233170	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,013,460	6,055,655	9,069,115	0.389491	59.00
60.00	06000	LABORATORY	2,834,336	10,247,307	13,081,643	0.833926	60.00
60.01	06001	ONCOLOGY	34,063	5,823,164	5,857,227	0.409585	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0.000000	60.02
65.00	06500	RESPIRATORY THERAPY	2,879,815	5,155,711	8,035,526	0.461721	65.00
66.00	06600	PHYSICAL THERAPY	5,795,905	4,401,796	10,197,701	0.356541	66.00
69.00	06900	ELECTROCARDIOLOGY	3,597,945	6,081,701	9,679,646	0.244246	69.00
69.01	06901	CARDIAC REHAB	0	777,186	777,186	0.589421	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,633,880	57,633,386	65,267,266	0.204488	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	629,837	629,837	1.606416	90.00
91.00	09100	EMERGENCY	9,779,991	57,182,777	66,962,768	0.152608	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	333,842	5,051,958	5,385,800	0.599164	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	4,339,127	4,339,127	0.583724	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	112,028,483	281,449,497	393,477,980		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	112,028,483	281,449,497	393,477,980		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150011

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

Worksheet C  
Part I  
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
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
42.00	04200 SUBPROVIDER				42.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
60.01	06001 ONCOLOGY	0.000000			60.01
60.02	06002 RADIATION ONCOLOGY	0.000000			60.02
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
69.01	06901 CARDIAC REHAB	0.000000			69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000			92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part I Date/Time Prepared: 11/23/2016 9:25 am
		Title XVIII	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,619,284	0	2,619,284	16,592	157.86	30.00
31.00	INTENSIVE CARE UNIT	646,487		646,487	4,309	150.03	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	555,317	0	555,317	3,086	179.95	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	44,107		44,107	2,045	21.57	43.00
200.00	Total (Lines 30-199)	3,865,195		3,865,195	26,032		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	6,946	1,096,496				
31.00	INTENSIVE CARE UNIT	1,919	287,908				
40.00	SUBPROVIDER - IPF	0	0				
41.00	SUBPROVIDER - IRF	2,518	453,114				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	11,383	1,837,518				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part II Date/Time Prepared: 11/23/2016 9:25 am
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Cost Center Description		Title XVIII			Hospital	PPS		
		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,949,780	100,938,782	0.019316	14,399,079	278,133	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,132,902	26,061,161	0.043471	939,021	40,820	54.00
57.00	05700	CT SCAN	98,164	30,953,528	0.003171	2,550,843	8,089	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	97,144	3,610,520	0.026906	192,684	5,184	58.00
59.00	05900	CARDIAC CATHETERIZATION	297,721	9,069,115	0.032828	1,101,992	36,176	59.00
60.00	06000	LABORATORY	782,035	13,081,643	0.059781	1,519,080	90,812	60.00
60.01	06001	ONCOLOGY	40,904	5,857,227	0.006984	21,928	153	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0.000000	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	293,201	8,035,526	0.036488	1,513,844	55,237	65.00
66.00	06600	PHYSICAL THERAPY	113,462	10,197,701	0.011126	1,945,166	21,642	66.00
69.00	06900	ELECTROCARDIOLOGY	419,233	9,679,646	0.043311	1,993,395	86,336	69.00
69.01	06901	CARDIAC REHAB	72,224	777,186	0.092930	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	347,964	65,267,266	0.005331	3,768,830	20,092	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	152,089	629,837	0.241474	0	0	90.00
91.00	09100	EMERGENCY	780,099	66,962,768	0.011650	4,650,069	54,173	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	453,384	5,385,800	0.084181	300,263	25,276	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	7,030,306	356,507,706		34,896,194	722,123	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part III Date/Time Prepared: 11/23/2016 9:25 am
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Cost Center Description			Title XVIII			Hospital		PPS	
			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	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School		
			6.00	7.00	8.00	9.00	11.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	16,592	0.00	6,946	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,309	0.00	1,919	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0.00	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	3,086	0.00	2,518	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0	0	0	42.00
43.00	04300	NURSERY	2,045	0.00	0	0	0	0	43.00
200.00		Total (lines 30-199)	26,032		11,383	0	0	0	200.00
Cost Center Description			PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost					
			12.00	13.00					
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0					30.00
31.00	03100	INTENSIVE CARE UNIT	0	0					31.00
40.00	04000	SUBPROVIDER - IPF	0	0					40.00
41.00	04100	SUBPROVIDER - IRF	0	0					41.00
42.00	04200	SUBPROVIDER	0	0					42.00
43.00	04300	NURSERY	0	0					43.00
200.00		Total (lines 30-199)	0	0					200.00



APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/23/2016 9:25 am
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Cost Center Description	Title XVIII				Hospital		PPS
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	ONCOLOGY	0	0	0	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150011

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XVIII		Hospital		Inpatient Program Charges	
			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)	PPS		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	100,938,782	0.000000	0.000000	14,399,079	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	26,061,161	0.000000	0.000000	939,021	54.00
57.00	05700	CT SCAN	0	30,953,528	0.000000	0.000000	2,550,843	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,610,520	0.000000	0.000000	192,684	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,069,115	0.000000	0.000000	1,101,992	59.00
60.00	06000	LABORATORY	0	13,081,643	0.000000	0.000000	1,519,080	60.00
60.01	06001	ONCOLOGY	0	5,857,227	0.000000	0.000000	21,928	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0.000000	0.000000	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	8,035,526	0.000000	0.000000	1,513,844	65.00
66.00	06600	PHYSICAL THERAPY	0	10,197,701	0.000000	0.000000	1,945,166	66.00
69.00	06900	ELECTROCARDIOLOGY	0	9,679,646	0.000000	0.000000	1,993,395	69.00
69.01	06901	CARDIAC REHAB	0	777,186	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	65,267,266	0.000000	0.000000	3,768,830	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	629,837	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	66,962,768	0.000000	0.000000	4,650,069	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,385,800	0.000000	0.000000	300,263	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0.000000	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	356,507,706			34,896,194	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/23/2016 9:25 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	14,759,728	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	7,732,560	0	0	0	54.00
57.00	05700 CT SCAN	0	7,740,619	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1,013,269	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	2,831,193	0	0	0	59.00
60.00	06000 LABORATORY	0	1,760,011	0	0	0	60.00
60.01	06001 ONCOLOGY	0	2,546,385	0	0	0	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0	1,713,691	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	25,692	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	2,025,219	0	0	0	69.00
69.01	06901 CARDIAC REHAB	0	359,536	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	28,789,622	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	297,657	0	0	0	90.00
91.00	09100 EMERGENCY	0	11,777,017	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,108,372	0	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	84,480,571	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/23/2016 9:25 am
Title XVIII		Hospital	PPS

Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	
		23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
60.01	06001 ONCOLOGY	0	0	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	60.02
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
69.01	06901 CARDIAC REHAB	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150011

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

Worksheet D  
Part V  
Date/Time Prepared:  
11/23/2016 9:25 am

		Title XVIII		Hospital		PPS		
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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.196080	14,759,728	0	0	2,894,087	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.351314	7,732,560	0	0	2,716,557	54.00
57.00	05700	CT SCAN	0.046357	7,740,619	0	0	358,832	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.233170	1,013,269	0	0	236,264	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.389491	2,831,193	0	0	1,102,724	59.00
60.00	06000	LABORATORY	0.833926	1,760,011	1,462	0	1,467,719	60.00
60.01	06001	ONCOLOGY	0.409585	2,546,385	0	0	1,042,961	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.461721	1,713,691	0	0	791,247	65.00
66.00	06600	PHYSICAL THERAPY	0.356541	25,692	0	0	9,160	66.00
69.00	06900	ELECTROCARDIOLOGY	0.244246	2,025,219	0	0	494,652	69.00
69.01	06901	CARDIAC REHAB	0.589421	359,536	0	0	211,918	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.204488	28,789,622	0	34,269	5,887,132	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	1.606416	297,657	0	0	478,161	90.00
91.00	09100	EMERGENCY	0.152608	11,777,017	0	0	1,797,267	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.599164	1,108,372	0	0	664,097	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0.583724		0			95.00
200.00		Subtotal (see instructions)		84,480,571	1,462	34,269	20,152,778	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		84,480,571	1,462	34,269	20,152,778	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/23/2016 9:25 am
	Title XVIII	Hospital	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		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	1,219	0		60.00
60.01 06001 ONCOLOGY	0	0		60.01
60.02 06002 RADIATION ONCOLOGY	0	0		60.02
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
69.01 06901 CARDIAC REHAB	0	0		69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	7,008		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
200.00 Subtotal (see instructions)	1,219	7,008		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	1,219	7,008		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150011 Component CCN: 15T011		Period: From 07/01/2015 To 06/30/2016		Worksheet D Part II Date/Time Prepared: 11/23/2016 9:25 am	
		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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	1,949,780	100,938,782	0.019316	37,676	728	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,132,902	26,061,161	0.043471	38,617	1,679	54.00
57.00	05700 CT SCAN	98,164	30,953,528	0.003171	60,785	193	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	97,144	3,610,520	0.026906	7,999	215	58.00
59.00	05900 CARDIAC CATHETERIZATION	297,721	9,069,115	0.032828	4,165	137	59.00
60.00	06000 LABORATORY	782,035	13,081,643	0.059781	71,388	4,268	60.00
60.01	06001 ONCOLOGY	40,904	5,857,227	0.006984	483	3	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	0.000000	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	293,201	8,035,526	0.036488	104,313	3,806	65.00
66.00	06600 PHYSICAL THERAPY	113,462	10,197,701	0.011126	2,505,610	27,877	66.00
69.00	06900 ELECTROCARDIOLOGY	419,233	9,679,646	0.043311	37,784	1,636	69.00
69.01	06901 CARDIAC REHAB	72,224	777,186	0.092930	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	347,964	65,267,266	0.005331	413,352	2,204	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	152,089	629,837	0.241474	0	0	90.00
91.00	09100 EMERGENCY	780,099	66,962,768	0.011650	52,132	607	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	5,385,800	0.000000	33,579	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	6,576,922	356,507,706		3,367,883	43,353	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150011 Component CCN: 15T011	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/23/2016 9:25 am
	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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 ONCOLOGY	0	0	0	0	0	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	0	0	0	60.02
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
69.01	06901 CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	0	0	0	0	0	200.00



APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150011 Component CCN: 15T011	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/23/2016 9:25 am
	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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	100,938,782	0.000000	0.000000	37,676	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	26,061,161	0.000000	0.000000	38,617	54.00
57.00	05700 CT SCAN	0	30,953,528	0.000000	0.000000	60,785	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	3,610,520	0.000000	0.000000	7,999	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	9,069,115	0.000000	0.000000	4,165	59.00
60.00	06000 LABORATORY	0	13,081,643	0.000000	0.000000	71,388	60.00
60.01	06001 ONCOLOGY	0	5,857,227	0.000000	0.000000	483	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	0.000000	0.000000	0	60.02
65.00	06500 RESPIRATORY THERAPY	0	8,035,526	0.000000	0.000000	104,313	65.00
66.00	06600 PHYSICAL THERAPY	0	10,197,701	0.000000	0.000000	2,505,610	66.00
69.00	06900 ELECTROCARDIOLOGY	0	9,679,646	0.000000	0.000000	37,784	69.00
69.01	06901 CARDIAC REHAB	0	777,186	0.000000	0.000000	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	65,267,266	0.000000	0.000000	413,352	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	629,837	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	66,962,768	0.000000	0.000000	52,132	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	5,385,800	0.000000	0.000000	33,579	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0.000000	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	356,507,706			3,367,883	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150011 Component CCN: 15T011	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/23/2016 9:25 am
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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 ONCOLOGY	0	0	0	0	0	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	0	0	0	60.02
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
69.01	06901 CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150011 Component CCN: 15T011	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/23/2016 9:25 am PPS
Title XVIII		Subprovider - IRF	

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
60.01	06001 ONCOLOGY	0	0	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	60.02
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
69.01	06901 CARDIAC REHAB	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (lines 50-199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/23/2016 9:25 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		16,592	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		16,592	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)		13,720	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)		6,946	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		18,642,809	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		18,642,809	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		18,642,809	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,123.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		7,804,526	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)		7,804,526	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/23/2016 9:25 am	
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)	
NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00	
42.00	Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	42.00
43.00	INTENSIVE CARE UNIT	6,170,877	4,309	1,432.09	1,919	2,748,181	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)					8,561,046	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					19,113,753	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)					1,384,404	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					722,123	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,106,527	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					17,007,226	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)					2,872	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,123.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,226,979	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/23/2016 9:25 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,619,284	18,642,809	0.140498	3,226,979	453,384	90.00
91.00	Nursing School cost	0	18,642,809	0.000000	3,226,979	0	91.00
92.00	Allied health cost	0	18,642,809	0.000000	3,226,979	0	92.00
93.00	All other Medical Education	0	18,642,809	0.000000	3,226,979	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1
		Component CCN: 15T011		Date/Time Prepared: 11/23/2016 9:25 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,086	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,086	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)		3,086	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)		2,518	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,878,553	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)		3,878,553	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,878,553	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,256.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,164,673	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,164,673	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1	
		Component CCN: 15T011				Date/Time Prepared: 11/23/2016 9:25 am	
		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)					1,150,337		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,315,010		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)					453,114		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					43,353		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					496,467		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,818,543		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: 150011 Component CCN: 15T011		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/23/2016 9:25 am	
		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	555,317	3,878,553	0.143176	0	0	90.00
91.00	Nursing School cost	0	3,878,553	0.000000	0	0	91.00
92.00	Allied health cost	0	3,878,553	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,878,553	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 11/23/2016 9:25 am
Cost Center Description			Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		16,592	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		16,592	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)		13,720	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)		433	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)		2,045	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		18,642,809	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		18,642,809	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		18,642,809	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,123.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		486,519	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)		486,519	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1	
Date/Time Prepared: 11/23/2016 9:25 am		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)		
42.00 NURSERY (title V & XIX only)	2,287,535	2,045	1,118.60	0		0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	6,170,877	4,309	1,432.09	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)						182,040	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						668,559	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)						2,872	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,123.60	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						3,226,979	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/23/2016 9:25 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,619,284	18,642,809	0.140498	3,226,979	453,384	90.00
91.00	Nursing School cost	0	18,642,809	0.000000	3,226,979	0	91.00
92.00	Allied health cost	0	18,642,809	0.000000	3,226,979	0	92.00
93.00	All other Medical Education	0	18,642,809	0.000000	3,226,979	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1
		Component CCN: 15T011		Date/Time Prepared: 11/23/2016 9:25 am
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,086	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,086	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)		3,086	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)		0	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)		2,045	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,878,553	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)		3,878,553	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,878,553	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,256.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	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)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1	
		Component CCN: 15T011				Date/Time Prepared: 11/23/2016 9:25 am	
		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
<b>Intensive Care Type Inpatient Hospital Units</b>							
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)					0		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
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
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
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: 150011 Component CCN: 15T011		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/23/2016 9:25 am	
		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	555,317	3,878,553	0.143176	0	0	90.00
91.00	Nursing School cost	0	3,878,553	0.000000	0	0	91.00
92.00	Allied health cost	0	3,878,553	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,878,553	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 11/23/2016 9:25 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		8,170,103	30.00
31.00	03100	INTENSIVE CARE UNIT		4,246,188	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.196080	14,399,079	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.351314	939,021	54.00
57.00	05700	CT SCAN	0.046357	2,550,843	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.233170	192,684	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.389491	1,101,992	59.00
60.00	06000	LABORATORY	0.833926	1,519,080	60.00
60.01	06001	ONCOLOGY	0.409585	21,928	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.461721	1,513,844	65.00
66.00	06600	PHYSICAL THERAPY	0.356541	1,945,166	66.00
69.00	06900	ELECTROCARDIOLOGY	0.244246	1,993,395	69.00
69.01	06901	CARDIAC REHAB	0.589421	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.204488	3,768,830	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	1.606416	0	90.00
91.00	09100	EMERGENCY	0.152608	4,650,069	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.599164	300,263	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		34,896,194	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)		34,896,194	202.00



INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150011 Component CCN: 15T011	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 11/23/2016 9:25 am	
		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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
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		3,282,432		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.196080	37,676	7,388	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.351314	38,617	13,567	54.00
57.00	05700 CT SCAN	0.046357	60,785	2,818	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.233170	7,999	1,865	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.389491	4,165	1,622	59.00
60.00	06000 LABORATORY	0.833926	71,388	59,532	60.00
60.01	06001 ONCOLOGY	0.409585	483	198	60.01
60.02	06002 RADIATION ONCOLOGY	0.000000	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0.461721	104,313	48,164	65.00
66.00	06600 PHYSICAL THERAPY	0.356541	2,505,610	893,353	66.00
69.00	06900 ELECTROCARDIOLOGY	0.244246	37,784	9,229	69.00
69.01	06901 CARDIAC REHAB	0.589421	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.204488	413,352	84,526	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	1.606416	0	0	90.00
91.00	09100 EMERGENCY	0.152608	52,132	7,956	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.599164	33,579	20,119	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		3,367,883	1,150,337	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)		3,367,883		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 11/23/2016 9:25 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		514,603	30.00
31.00	03100	INTENSIVE CARE UNIT		115,746	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.196080	339,360	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.351314	15,556	54.00
57.00	05700	CT SCAN	0.046357	35,591	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.233170	656	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.389491	14,717	59.00
60.00	06000	LABORATORY	0.833926	42,252	60.00
60.01	06001	ONCOLOGY	0.409585	0	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.461721	44,169	65.00
66.00	06600	PHYSICAL THERAPY	0.356541	11,052	66.00
69.00	06900	ELECTROCARDIOLOGY	0.244246	24,535	69.00
69.01	06901	CARDIAC REHAB	0.589421	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.204488	95,424	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	1.606416	0	90.00
91.00	09100	EMERGENCY	0.152608	114,169	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.599164	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		737,481	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)		737,481	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/23/2016 9:25 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
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)		3,635,031	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		11,667,924	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)		71,453	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)		89.15	4.00
<b>Indirect Medical Education Adjustment</b>				
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
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
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
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		7.05	30.00
31.00	Percentage of Medicaid patient days (see instructions)		25.12	31.00
32.00	Sum of lines 30 and 31		32.17	32.00
33.00	Allowable disproportionate share percentage (see instructions)		15.75	33.00
34.00	Disproportionate share adjustment (see instructions)		602,554	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/23/2016 9:25 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
<b>Uncompensated Care Adjustment</b>				
35.00	Total uncompensated care amount (see instructions)	7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000147542	0.000148874	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,128,349	953,711	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	284,406	713,980	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	998,386		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	16,975,348		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	16,856,610		48.00
				<b>Amount</b>
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		16,975,348	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,244,441	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		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)		18,219,789	59.00
60.00	Primary payer payments		3,461	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		18,216,328	61.00
62.00	Deductibles billed to program beneficiaries		2,076,844	62.00
63.00	Coinurance billed to program beneficiaries		19,138	63.00
64.00	Allowable bad debts (see instructions)		144,961	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		94,225	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		52,886	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		16,214,571	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)		47,231	70.93
70.94	HRR adjustment amount (see instructions)		0	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/23/2016 9:25 am	
		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)		126,251		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		16,135,551		71.00
71.01	Sequestration adjustment (see instructions)		322,711		71.01
72.00	Interim payments		16,332,354		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)		-519,514		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		370,173		75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>					
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	
<b>HSP Bonus Payment Amount</b>					
100.00	HSP bonus amount (see instructions)		0		100.00
<b>HVBP Adjustment for HSP Bonus Payment</b>					
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		102.00
<b>HRR Adjustment for HSP Bonus Payment</b>					
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		104.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 150011		Period: From 07/01/2015 To 06/30/2016		Worksheet DSH	
		Title XVIII		Hospital		Date/Time Prepared: 11/23/2016 9:25 am	
		PPS					
		Original .mcrcx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	7.05	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	25.12	0.00			25.12	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	32.17	0.00			25.12	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	RRC				RRC	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	89.15	0.00			89.15	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	15.75	0.00			9.94	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	Yes				Yes	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	1.83	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	433	0			433	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	1,841	0			1,841	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	2,808	0			2,808	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	5,082	0			5,082	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	20,074	0			20,074	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	160	0			160	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	20,234	0			20,234	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	25.12	0.00			25.12	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 150011		Period: From 07/01/2015 To 06/30/2016		Worksheet DSH Date/Time Prepared: 11/23/2016 9:25 am	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
<b>CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE</b>							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	15.76		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		15.76		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		15.76		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
<b>DETERMINATION OF PROVIDER TYPE</b>							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	True				True	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	True				True	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Rural				Rural	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet DSH Date/Time Prepared: 11/23/2016 9:25 am
		Title XVIII	Hospital	PPS

		Revised Percentage	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE		6.00	
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	9.94	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00	29.00
30.00	Line 28 or 29 as applicable	9.94	30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	9.94	31.00



LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150011

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
11/23/2016 9:25 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,635,031	0	3,635,031		3,635,031	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	11,667,924	0		11,667,924	11,667,924	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	71,453	0	29,294	42,159	71,453	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
<b>Indirect Medical Education Adjustment</b>								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1575	0.1575	0.1575	0.1575		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	602,554	0	143,129	459,425	602,554	11.00
11.01	Uncompensated care payments	36.00	998,386	0	284,406	713,980	998,386	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	16,975,348	0	4,091,860	12,883,488	16,975,348	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	16,856,610	0	4,214,153	12,642,457	16,856,610	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	16,975,348	0	4,091,860	12,883,488	16,975,348	15.00
16.00	Payment for inpatient program capital	50.00	1,244,441	0	297,106	947,335	1,244,441	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150011

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
11/23/2016 9:25 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	4,388,966	13,830,823	18,219,789	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,225,274	0	290,497	934,777	1,225,274	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	19,167	0	6,609	12,558	19,167	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,244,441	0	297,106	947,335	1,244,441	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/23/2016 9:25 am
Title XVIII			Hospital	PPS

	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)	
	0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00				1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,635,031	3,635,031		3,635,031
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	11,667,924		11,667,924	11,667,924
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00	71,453	29,294	42,159	71,453
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0
<b>Indirect Medical Education Adjustment</b>						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0
<b>Disproportionate Share Adjustment</b>						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1575	0.1575	0.1575	
11.00	Disproportionate share adjustment (see instructions)	34.00	602,554	143,129	459,425	602,554
11.01	Uncompensated care payments	36.00	998,386	284,406	713,980	998,386
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0
13.00	Subtotal (see instructions)	47.00	16,975,348	4,091,860	12,883,488	16,975,348
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	16,856,610	4,214,153	12,642,457	16,856,610
15.00	Total payment for inpatient operating costs (see instructions)	49.00	16,975,348	4,091,860	12,883,488	16,975,348
16.00	Payment for inpatient program capital	50.00	1,244,441	1,541,547	-297,106	1,244,441
17.00	Special add-on payments for new technologies	54.00	0	0	0	0
17.01	Net organ acquisition cost	55.00	0	0	0	0
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0
19.00	<b>SUBTOTAL</b>			5,633,407	12,586,382	18,219,789

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 150011

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

Worksheet E  
Part A Exhibit 5  
Date/Time Prepared:  
11/23/2016 9:25 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,225,274	1,515,771	-290,497	1,225,274	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	19,167	25,776	-6,609	19,167	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,244,441	1,541,547	-297,106	1,244,441	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	47,231	8,476	38,755	47,231	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	126,251	126,251	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/23/2016 9:25 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		8,227	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		20,152,778	2.00
3.00	PPS payments		17,250,483	3.00
4.00	Outlier payment (see instructions)		181,375	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)		8,227	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		35,731	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)		35,731	14.00
<b>Customary charges</b>				
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 charge basis 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)		35,731	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		27,504	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)		8,227	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)		17,431,858	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)		3,599,592	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)		13,840,493	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)		13,840,493	30.00
31.00	Primary payer payments		3,926	31.00
32.00	Subtotal (line 30 minus line 31)		13,836,567	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		988,037	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		642,224	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		644,017	36.00
37.00	Subtotal (see instructions)		14,478,791	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-186	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)		14,478,977	40.00
40.01	Sequestration adjustment (see instructions)		289,580	40.01
41.00	Interim payments		14,129,344	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		60,053	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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
			Overrides	
			1.00	
<b>WORKSHEET OVERRIDE VALUES</b>				
112.00	Override of Ancillary service charges (line 12)			0.112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150011

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/23/2016 9:25 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		16,249,399		13,553,923	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	06/30/2016	82,955	06/30/2016	468,321	3.01	
3.02			0	06/30/2016	107,100	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)		82,955		575,421	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)		16,332,354		14,129,344	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		60,053	6.01	
6.02	SETTLEMENT TO PROGRAM		519,514		0	6.02	
7.00	Total Medicare program liability (see instructions)		15,812,840		14,189,397	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: 150011  
Component CCN: 15T011

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/23/2016 9:25 am  
PPS

Title XVIII

Subprovider -  
IRF

		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					1.00
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		3,956,378		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)		3,956,378		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		15,072		0	6.02
7.00	Total Medicare program liability (see instructions)		3,941,306		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part II Date/Time Prepared: 11/23/2016 9:25 am
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		5,198	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		8,865	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		2,187	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		18,029	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		393,477,980	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		8,835,152	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)		881,013	8.00
9.00	Sequestration adjustment amount (see instructions)		17,620	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		863,393	10.00
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)		932,678	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)		-69,285	32.00
				<b>Overrides</b>
				1.00
<b>CONTRACTOR OVERRIDES</b>				
108.00	Override of HIT payment			0108.00



CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150011 Component CCN: 15T011	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part III Date/Time Prepared: 11/23/2016 9:25 am
		Title VIII	Subprovider - IRF	PPS
				1.00
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)			3,889,276 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0183 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			96,843 3.00
4.00	Outlier Payments			87,849 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)			8.431694 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)			4,073,968 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)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			4,073,968 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			4,073,968 19.00
20.00	Deductibles			38,052 20.00
21.00	Subtotal (line 19 minus line 20)			4,035,916 21.00
22.00	Coinsurance			14,175 22.00
23.00	Subtotal (line 21 minus line 22)			4,021,741 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)			4,021,741 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)			4,021,741 32.00
32.01	Sequestration adjustment (see instructions)			80,435 32.01
33.00	Interim payments			3,956,378 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)			-15,072 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			24,873 36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			87,849 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: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part VII Date/Time Prepared: 11/23/2016 9:25 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		668,559		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)		668,559	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)		668,559	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		630,349		8.00
9.00	Ancillary service charges		737,481	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)		1,367,830	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		1,367,830	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		699,271	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)		668,559	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		668,559	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		668,559	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		668,559	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		668,559	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)		668,559	0	40.00
41.00	Interim payments		670,827	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-2,268	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
<b>OVERRIDES</b>					
109.00	Override Ancillary service charges (line 9)		0	0	109.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150011 Component CCN: 15T011	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part VII Date/Time Prepared: 11/23/2016 9:25 am
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>				
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient hospital/SNF/NF services	0		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)	0	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)	0	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	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)	0	0	12.00
<b>CUSTOMARY CHARGES</b>				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	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)	0	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	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)	0	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	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
<b>OVERRIDES</b>				
109.00	Override Ancillary service charges (line 9)	0	0	109.00

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

Provider CCN: 150011

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

Worksheet G  
Date/Time Prepared:  
11/23/2016 9:25 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	26,241,190	0	0	0	1.00
2.00	Temporary investments	3,900,911	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	53,524,601	0	0	0	4.00
5.00	Other receivable	1,691,428	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-34,282,223	0	0	0	6.00
7.00	Inventory	1,505,584	0	0	0	7.00
8.00	Prepaid expenses	2,194,280	0	0	0	8.00
9.00	Other current assets	795,880	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	55,571,651	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	4,646,548	0	0	0	12.00
13.00	Land improvements	3,353,531	0	0	0	13.00
14.00	Accumulated depreciation	-2,172,862	0	0	0	14.00
15.00	Buildings	113,907,381	0	0	0	15.00
16.00	Accumulated depreciation	-64,263,711	0	0	0	16.00
17.00	Leasehold improvements	2,473,673	0	0	0	17.00
18.00	Accumulated depreciation	-916,091	0	0	0	18.00
19.00	Fixed equipment	1,005,608	0	0	0	19.00
20.00	Accumulated depreciation	-870,167	0	0	0	20.00
21.00	Automobiles and trucks	1,070,672	0	0	0	21.00
22.00	Accumulated depreciation	-622,641	0	0	0	22.00
23.00	Major movable equipment	77,622,878	0	0	0	23.00
24.00	Accumulated depreciation	-62,202,369	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	8,665,003	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	81,697,453	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	206,284,018	10,155	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	8,916,922	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	215,200,940	10,155	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	352,470,044	10,155	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	4,676,289	0	0	0	37.00
38.00	Salaries, wages, and fees payable	8,618,051	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,975,491	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	18,269,831	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	94,029,897	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	94,029,897	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	112,299,728	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	240,170,316				52.00
53.00	Specific purpose fund		10,155			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)	240,170,316	10,155	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	352,470,044	10,155	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150011

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

Worksheet G-1

Date/Time Prepared:  
11/23/2016 9:25 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		234,937,237		10,155	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		5,233,079			2.00
3.00	Total (sum of line 1 and line 2)		240,170,316		10,155	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		240,170,316		10,155	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		240,170,316		10,155	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150011

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
11/23/2016 9:25 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	18,768,864		18,768,864	1.00
2.00	SUBPROVIDER - IPF	4,024,144		4,024,144	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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)	22,793,008		22,793,008	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	8,773,212		8,773,212	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)	8,773,212		8,773,212	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	31,566,220		31,566,220	17.00
18.00	Ancillary services	80,342,929	0	80,342,929	18.00
19.00	Outpatient services	0	282,254,249	282,254,249	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	4,354,276	4,354,276	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN	0	24,803,462	24,803,462	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	111,909,149	311,411,987	423,321,136	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		163,882,415		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	ELIMINATIONS	948,870			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		948,870		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		162,933,545		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150011

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

Worksheet G-3

Date/Time Prepared:  
11/23/2016 9:25 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	423,321,136	1.00
2.00	Less contractual allowances and discounts on patients' accounts	259,817,317	2.00
3.00	Net patient revenues (line 1 minus line 2)	163,503,819	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	162,933,545	4.00
5.00	Net income from service to patients (line 3 minus line 4)	570,274	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,977,581	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	3,028,600	24.00
25.00	Total other income (sum of lines 6-24)	5,006,181	25.00
26.00	Total (line 5 plus line 25)	5,576,455	26.00
27.00	BAD DEBT EXPENSE	343,376	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	343,376	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,233,079	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150011	Period: From 07/01/2015 To 06/30/2016	Worksheet L Parts I-III Date/Time Prepared: 11/23/2016 9:25 am
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		1,225,274	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		19,167	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)		49.70	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,244,441	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
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
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
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