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
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1330	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/26/2017 12:27 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/26/2017 Time: 12:27 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ADAMS MEMORIAL HOSPITAL (15-1330) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	363,785	189,477	0	0	1.00
2.00	Subprovider - IPF	0	13,130	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-49,234	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	327,681	189,477	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2017 12:15 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1100 MERCER AVENEUE	PO Box:			1.00
2.00	City: DECATUR	State: IN	Zip Code: 46733	County: ADAMS	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ADAMS MEMORIAL HOSPITAL	151330	99915	1	11/01/2005	N	O	P	3.00
4.00	Subprovider - IPF	ADAMS MEMORIAL HOSPITAL	15M330	99915	4	11/01/2005	N	P	P	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ADAMS MEMORIAL HOSPITAL	15Z330	99915		11/01/2005	N	O	P	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)	01/01/2016	12/31/2016	20.00
21.00	Type of Control (see instructions)	9		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2017 12:15 pm

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	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	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2017 12:15 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2017 12:15 pm

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

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

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

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

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

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

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

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	128,085	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2017 12:15 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H060	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: ADAMS HEALTH NETWORK	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 1100 MERCER AVE	PO Box:		142.00
143.00	City: DECATUR	State: IN	Zip Code: 46733	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	N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1330	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/26/2017 12:15 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2016	09/30/2017	170.00
		1.00	2.00	
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 in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2017 12:15 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	05/08/2017	Y	05/08/2017	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 5/26/2017 12:15 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SKANDER		NASSER		41.00
42.00	Enter the employer/company name of the cost report preparer.	BRADLEY ASSOCIATES				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-237-5500		SKANDERN@BRADLEYCPA.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1330	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/26/2017 12:15 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PARTNER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/26/2017 12:15 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,686	91,008.00	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)		21	7,686	91,008.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,464	9,552.00	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)		25	9,150	100,560.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3,660		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			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	89.00				0	26.25
27.00	Total (sum of lines 14-26)		35				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: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2017 12:15 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,594	171	3,726			1.00
2.00	HMO and other (see instructions)	668	0				2.00
3.00	HMO IPF Subprovider	107	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	265	0	265			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	317			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,859	171	4,308			7.00
8.00	INTENSIVE CARE UNIT	200	4	398			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		59	380			13.00
14.00	Total (see instructions)	2,059	234	5,086	0.00	484.76	14.00
15.00	CAH visits	30,239	6,035	128,515			15.00
16.00	SUBPROVIDER - IPF	357	106	1,550	0.00	20.68	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	505.44	27.00
28.00	Observation Bed Days		0	1,344			28.00
29.00	Ambulance Trips	680					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	66			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: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/26/2017 12:15 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	454	65	1,597	1.00
2.00	HMO and other (see instructions)			156	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	454	65	1,597	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	50	27	346	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					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	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 5/26/2017 12:15 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.439316	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,716,993	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	9,464,322	6.00
7.00	Medicaid cost (line 1 times line 6)	4,157,828	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)	2,440,835	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	100,000	9.00
10.00	Stand-alone CHIP charges	200,000	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	87,863	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (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 , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,440,835	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	178,551	0	178,551	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	78,440	0	78,440	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	78,440	0	78,440	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,920,368	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	205,508	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	3,714,860	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,631,997	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,710,437	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,151,272	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/26/2017 12:15 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,631,300	2,631,300	52,181	2,683,481	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	18,988	18,988	0	18,988	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,217,663	7,240,082	9,457,745	-217,712	9,240,033	5.00
7.00	00700	OPERATION OF PLANT	183,004	641,987	824,991	0	824,991	7.00
7.01	00701	BIO-MEDICAL	3,518	130,121	133,639	0	133,639	7.01
7.02	00702	UTILITIES - HOSPITAL	0	702,427	702,427	5,467	707,894	7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	0	108,745	108,745	-5,467	103,278	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	43,966	154,629	198,595	0	198,595	8.00
9.00	00900	HOUSEKEEPING	437,869	293,143	731,012	0	731,012	9.00
10.00	01000	DIETARY	691,086	734,408	1,425,494	-1,166,670	258,824	10.00
11.00	01100	CAFETERIA	0	0	0	1,166,670	1,166,670	11.00
13.00	01300	NURSING ADMINISTRATION	843,588	242,065	1,085,653	0	1,085,653	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	721,117	493,932	1,215,049	0	1,215,049	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	395,414	756,564	1,151,978	0	1,151,978	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,172,828	824,389	2,997,217	472,594	3,469,811	30.00
31.00	03100	INTENSIVE CARE UNIT	590,494	223,275	813,769	0	813,769	31.00
40.00	04000	SUBPROVIDER - IPF	795,561	402,036	1,197,597	0	1,197,597	40.00
43.00	04300	NURSERY	0	0	0	253,318	253,318	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,516,270	1,440,518	3,956,788	0	3,956,788	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	663,089	276,345	939,434	-725,912	213,522	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,018,844	1,209,813	2,228,657	0	2,228,657	54.00
60.00	06000	LABORATORY	1,042,939	2,312,023	3,354,962	0	3,354,962	60.00
65.00	06500	RESPIRATORY THERAPY	647,774	295,454	943,228	0	943,228	65.00
66.00	06600	PHYSICAL THERAPY	789,050	283,637	1,072,687	0	1,072,687	66.00
67.00	06700	OCCUPATIONAL THERAPY	267,444	99,928	367,372	0	367,372	67.00
68.00	06800	SPEECH PATHOLOGY	178,590	56,487	235,077	0	235,077	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,797,446	1,797,446	0	1,797,446	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,569,437	1,569,437	0	1,569,437	73.00
76.00	03020	OP PSYCH	329,248	119,279	448,527	14,072	462,599	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,039,404	443,607	1,483,011	0	1,483,011	90.00
90.01	09001	CLINIC - AMO	1,098,398	213,237	1,311,635	0	1,311,635	90.01
90.02	09002	CLINIC - AMH NEURO	240,764	42,267	283,031	0	283,031	90.02
90.03	09003	CLINIC - NIGLIAZZO	1,116,147	227,965	1,344,112	0	1,344,112	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	18,192	34,967	53,159	0	53,159	90.04
91.00	09100	EMERGENCY	2,165,406	457,810	2,623,216	261,747	2,884,963	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,129,980	550,527	1,680,507	0	1,680,507	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,357,647	27,028,838	50,386,485	110,288	50,496,773	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	741,842	411,589	1,153,431	0	1,153,431	194.01
194.02	07952	OTHER MOBS	385,197	398,252	783,449	-55,219	728,230	194.02
194.03	07953	MONROE	551,194	342,021	893,215	-55,069	838,146	194.03
200.00		TOTAL (SUM OF LINES 118-199)	25,035,880	28,180,700	53,216,580	0	53,216,580	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/26/2017 12:15 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-330,184	2,353,297		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	18,988		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	39,305	9,279,338		5.00
7.00	00700	OPERATION OF PLANT	-73,619	751,372		7.00
7.01	00701	BIO-MEDICAL	-125,417	8,222		7.01
7.02	00702	UTILITIES - HOSPITAL	-34,852	673,042		7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	0	103,278		7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	198,595		8.00
9.00	00900	HOUSEKEEPING	0	731,012		9.00
10.00	01000	DIETARY	0	258,824		10.00
11.00	01100	CAFETERIA	-448,232	718,438		11.00
13.00	01300	NURSING ADMINISTRATION	-15,944	1,069,709		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	0	1,215,049		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-25,363	1,126,615		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-851,116	2,618,695		30.00
31.00	03100	INTENSIVE CARE UNIT	-584	813,185		31.00
40.00	04000	SUBPROVIDER - IPF	-244,499	953,098		40.00
43.00	04300	NURSERY	0	253,318		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,815,433	2,141,355		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	213,522		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,228,657		54.00
60.00	06000	LABORATORY	-48,920	3,306,042		60.00
65.00	06500	RESPIRATORY THERAPY	-103,804	839,424		65.00
66.00	06600	PHYSICAL THERAPY	0	1,072,687		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	367,372		67.00
68.00	06800	SPEECH PATHOLOGY	0	235,077		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,797,446		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-606,060	963,377		73.00
76.00	03020	OP PSYCH	0	462,599		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-788,162	694,849		90.00
90.01	09001	CLINIC - AMO	-749,033	562,602		90.01
90.02	09002	CLINIC - AMH NEURO	0	283,031		90.02
90.03	09003	CLINIC - NIGLIAZZO	-999,235	344,877		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	53,159		90.04
91.00	09100	EMERGENCY	-1,363,646	1,521,317		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	1,680,507		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-8,584,798	41,911,975		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	TITLE XX	0	0		194.00
194.01	07951	OTHER NRCC	0	1,153,431		194.01
194.02	07952	OTHER MOBS	0	728,230		194.02
194.03	07953	MONROE	0	838,146		194.03
200.00		TOTAL (SUM OF LINES 118-199)	-8,584,798	44,631,782		200.00

RECLASSIFICATIONS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/26/2017 12:15 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - OB, NURSERY AND L&D				
1.00	ADULTS & PEDIATRICS	30.00	346,005	126,589	1.00
2.00	NURSERY	43.00	185,464	67,854	2.00
	0		531,469	194,443	
	B - INSURANCE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	52,181	1.00
	0		0	52,181	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	567,452	599,218	1.00
	0		567,452	599,218	
	D - ED RECLASS				
1.00	EMERGENCY	91.00	233,703	28,044	1.00
	TOTALS		233,703	28,044	
	E - HOSPITAL USE OF SWISS CITY				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,936	1.00
2.00	OP PSYCH	76.00	0	14,072	2.00
3.00	UTILITIES - HOSPITAL	7.02	0	5,467	3.00
	0		0	25,475	
	F - MANAGEMENT FEE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	90,280	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	90,280	
500.00	Grand Total: Increases		1,332,624	989,641	500.00

RECLASSIFICATIONS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/26/2017 12:15 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - OB, NURSERY AND L&D						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	531,469	194,443	0		1.00
2.00		0.00	0	0	0		2.00
	0		531,469	194,443			
	B - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	52,181	12		1.00
	0		0	52,181			
	C - CAFETERIA						
1.00	DIETARY	10.00	567,452	599,218	0		1.00
	0		567,452	599,218			
	D - ED RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	233,703	28,044	0		1.00
	TOTALS		233,703	28,044			
	E - HOSPITAL USE OF SWISS CITY						
1.00	OTHER MOBS	194.02	0	20,008	0		1.00
2.00	UTILITIES - OFFSITE BLDGS	7.03	0	5,467	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	25,475			
	F - MANAGEMENT FEE						
1.00	OTHER MOBS	194.02	0	35,211	0		1.00
2.00	MONROE	194.03	0	55,069	0		2.00
	TOTALS		0	90,280			
500.00	Grand Total: Decreases		1,332,624	989,641			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I Date/Time Prepared: 5/26/2017 12:15 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	367,244	0	0	0	0	1.00
2.00	Land Improvements	1,624,680	0	0	0	10,819	2.00
3.00	Buildings and Fixtures	38,317,830	2,048,916	0	2,048,916	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	4,591,700	23,240	0	23,240	0	5.00
6.00	Movable Equipment	23,447,242	797,215	0	797,215	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	68,348,696	2,869,371	0	2,869,371	10,819	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	68,348,696	2,869,371	0	2,869,371	10,819	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	367,244	0	1.00
2.00	Land Improvements	1,613,861	0	2.00
3.00	Buildings and Fixtures	40,366,746	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	4,614,940	0	5.00
6.00	Movable Equipment	24,244,457	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	71,207,248	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	71,207,248	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part II Date/Time Prepared: 5/26/2017 12:15 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,512,027	0	1,119,273	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,512,027	0	1,119,273	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,631,300		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	2,631,300		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 5/26/2017 12:15 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	64,611,203	0	64,611,203	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	64,611,203	0	64,611,203	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,452,124	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,452,124	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	848,992	52,181	0	0	2,353,297	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	848,992	52,181	0	0	2,353,297	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/26/2017 12:15 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-219,797	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-7,410	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,728,316			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	-268,510			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-448,232	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-606,060	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-25,363	MEDICAL RECORDS & LIBRARY	16.00	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 - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/26/2017 12:15 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	IHA DUES	A	-911	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	AHA DUES	A	-3,382	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02			0		0.00	0	33.02
33.03	JAY COUNTY MGMT REVENUE	B	-139,479	SUBPROVIDER - IPF	40.00	0	33.03
33.04	WORTHMAN FITNESS CENTER	B	-103,804	RESPIRATORY THERAPY	65.00	0	33.04
33.05	MISC INCOME	B	-213,883	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	ECU RUN-OFF EXPENSES	A	-584	INTENSIVE CARE UNIT	31.00	0	33.06
33.07	HOSPITAL PROVIDER TAX SHORTFALL	A	455,246	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08			0		0.00	0	33.08
33.09	MARKETING	A	-266,120	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10			0		0.00	0	33.10
33.11			0		0.00	0	33.11
33.12	HOSPITALIST OTHER	A	-8,193	ADULTS & PEDIATRICS	30.00	0	33.12
33.13			0		0.00	0	33.13
33.14			0		0.00	0	33.14
33.15			0		0.00	0	33.15
33.16			0		0.00	0	33.16
33.17			0		0.00	0	33.17
33.18			0		0.00	0	33.18
33.19			0		0.00	0	33.19
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,584,798				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/26/2017 12:15 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX		78,913	74,143	1.00
2.00	1.00	NEW CAP REL COSTS-BLDG & FIX		0	59,903	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL		3,134,250	0	3.00
3.01	7.02	UTILITIES - HOSPITAL		0	34,852	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL		0	2,968,205	3.02
3.03	7.00	OPERATION OF PLANT		0	73,619	3.03
3.04	7.01	BIO-MEDICAL		0	125,417	3.04
3.05	5.00	ADMINISTRATIVE & GENERAL		0	35,211	3.05
3.06	5.00	ADMINISTRATIVE & GENERAL		0	55,069	3.06
4.00	1.00	NEW CAP REL COSTS-BLDG & FIX		0	55,254	4.00
5.00	0		0	3,213,163	3,481,673	5.00

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

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

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

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

6.00	B		0.00	ADAMS HEALTH NETWORK	0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/26/2017 12:15 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	4,770	11		1.00
2.00	-59,903	9		2.00
3.00	3,134,250	0		3.00
3.01	-34,852	0		3.01
3.02	-2,968,205	0		3.02
3.03	-73,619	0		3.03
3.04	-125,417	0		3.04
3.05	-35,211	0		3.05
3.06	-55,069	0		3.06
4.00	-55,254	11		4.00
5.00	-268,510			5.00

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

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

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

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

6.00	MANAGEMENT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 5/26/2017 12:15 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	13.00	NURSING ADMINISTRATION	15,944	15,944	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	842,923	842,923	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	105,020	105,020	0	0	0	3.00
4.00	50.00	OPERATING ROOM	1,815,433	1,815,433	0	0	0	4.00
5.00	60.00	LABORATORY	50,000	48,920	1,080	0	0	5.00
6.00	90.00	CLINIC	788,162	788,162	0	0	0	6.00
7.00	90.01	CLINIC - AMO	749,033	749,033	0	0	0	7.00
8.00	90.03	CLINIC - NIGLIAZZO	999,235	999,235	0	0	0	8.00
9.00	91.00	EMERGENCY	1,753,179	1,363,646	389,533	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			7,118,929	6,728,316	390,613		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	13.00	NURSING ADMINISTRATION	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	90.01	CLINIC - AMO	0	0	0	0	0	7.00
8.00	90.03	CLINIC - NIGLIAZZO	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	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	13.00	NURSING ADMINISTRATION	0	0	0	15,944		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	842,923		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	105,020		3.00
4.00	50.00	OPERATING ROOM	0	0	0	1,815,433		4.00
5.00	60.00	LABORATORY	0	0	0	48,920		5.00
6.00	90.00	CLINIC	0	0	0	788,162		6.00
7.00	90.01	CLINIC - AMO	0	0	0	749,033		7.00
8.00	90.03	CLINIC - NIGLIAZZO	0	0	0	999,235		8.00
9.00	91.00	EMERGENCY	0	0	0	1,363,646		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	6,728,316		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/26/2017 12:15 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,353,297	2,353,297				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	18,988	0	0	18,988		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,279,338	236,805	0	1,504	9,517,647	5.00
7.00	00700	OPERATION OF PLANT	751,372	360,811	0	139	1,112,322	7.00
7.01	00701	BIO-MEDICAL	8,222	6,129	0	3	14,354	7.01
7.02	00702	UTILITIES - HOSPITAL	673,042	0	0	0	673,042	7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	103,278	0	0	0	103,278	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	198,595	34,858	0	33	233,486	8.00
9.00	00900	HOUSEKEEPING	731,012	47,458	0	332	778,802	9.00
10.00	01000	DIETARY	258,824	25,080	0	94	283,998	10.00
11.00	01100	CAFETERIA	718,438	115,117	0	430	833,985	11.00
13.00	01300	NURSING ADMINISTRATION	1,069,709	11,834	0	639	1,082,182	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,215,049	33,184	0	547	1,248,780	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,126,615	51,188	0	300	1,178,103	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,618,695	339,503	0	1,917	2,960,115	30.00
31.00	03100	INTENSIVE CARE UNIT	813,185	63,526	0	448	877,159	31.00
40.00	04000	SUBPROVIDER - IPF	953,098	144,128	0	603	1,097,829	40.00
43.00	04300	NURSERY	253,318	33,749	0	141	287,208	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,141,355	221,060	0	1,907	2,364,322	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	213,522	23,951	0	100	237,573	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,228,657	178,521	0	772	2,407,950	54.00
60.00	06000	LABORATORY	3,306,042	64,756	0	791	3,371,589	60.00
65.00	06500	RESPIRATORY THERAPY	839,424	82,436	0	491	922,351	65.00
66.00	06600	PHYSICAL THERAPY	1,072,687	70,058	0	598	1,143,343	66.00
67.00	06700	OCCUPATIONAL THERAPY	367,372	2,016	0	203	369,591	67.00
68.00	06800	SPEECH PATHOLOGY	235,077	1,008	0	135	236,220	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,797,446	0	0	0	1,797,446	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	963,377	0	0	0	963,377	73.00
76.00	03020	OP PSYCH	462,599	0	0	250	462,849	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	694,849	0	0	788	695,637	90.00
90.01	09001	CLINIC - AMO	562,602	0	0	833	563,435	90.01
90.02	09002	CLINIC - AMH NEURO	283,031	0	0	182	283,213	90.02
90.03	09003	CLINIC - NIGLIAZZO	344,877	0	0	846	345,723	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	53,159	17,399	0	14	70,572	90.04
91.00	09100	EMERGENCY	1,521,317	112,092	0	1,819	1,635,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,680,507	0	0	857	1,681,364	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	41,911,975	2,276,667	0	17,716	41,834,073	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,185	0	0	13,185	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	1,153,431	63,445	0	562	1,217,438	194.01
194.02	07952	OTHER MOBS	728,230	0	0	292	728,522	194.02
194.03	07953	MONROE	838,146	0	0	418	838,564	194.03
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)	44,631,782	2,353,297	0	18,988	44,631,782	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/26/2017 12:15 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	BIO-MEDICAL	UTILITIES - HOSPITAL	UTILITIES - OFFSITE BLDGS	
			5.00	7.00	7.01	7.02	7.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,517,647					5.00
7.00	00700	OPERATION OF PLANT	301,494	1,413,816				7.00
7.01	00701	BIO-MEDICAL	3,891	3,911	22,156			7.01
7.02	00702	UTILITIES - HOSPITAL	182,427	0	0	855,469		7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	27,993	0	0	0	131,271	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	63,286	22,242	0	17,044	0	8.00
9.00	00900	HOUSEKEEPING	211,094	35,402	63	23,205	0	9.00
10.00	01000	DIETARY	76,977	16,003	8	12,263	0	10.00
11.00	01100	CAFETERIA	226,051	73,454	35	56,288	0	11.00
13.00	01300	NURSING ADMINISTRATION	293,324	7,551	0	5,787	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	338,481	21,174	42	16,226	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	319,324	32,662	0	25,029	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	802,336	216,632	3,239	166,005	0	30.00
31.00	03100	INTENSIVE CARE UNIT	237,753	40,535	113	31,062	0	31.00
40.00	04000	SUBPROVIDER - IPF	297,565	91,965	26	70,473	0	40.00
43.00	04300	NURSERY	77,847	21,535	271	16,502	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	640,847	141,055	5,019	108,091	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	64,394	15,283	182	11,711	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	652,672	113,912	9,752	87,291	0	54.00
60.00	06000	LABORATORY	913,864	50,504	924	31,663	0	60.00
65.00	06500	RESPIRATORY THERAPY	250,002	52,601	1,094	40,309	0	65.00
66.00	06600	PHYSICAL THERAPY	309,902	44,703	373	34,256	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	100,177	1,286	0	986	0	67.00
68.00	06800	SPEECH PATHOLOGY	64,027	643	0	493	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	487,196	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	261,122	0	0	0	0	73.00
76.00	03020	OP PSYCH	125,455	5,146	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	188,552	56,422	8	0	0	90.00
90.01	09001	CLINIC - AMO	152,718	25,149	0	0	7,973	90.01
90.02	09002	CLINIC - AMH NEURO	76,765	0	35	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	93,708	29,909	70	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	19,128	11,102	0	8,507	0	90.04
91.00	09100	EMERGENCY	443,227	71,524	166	54,809	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	455,732	55,612	694	0	9,856	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,759,331	1,257,917	22,114	818,000	17,829	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,574	8,413	0	6,447	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	329,985	89,418	42	31,022	16,137	194.01
194.02	07952	OTHER MOBS	197,465	36,019	0	0	89,548	194.02
194.03	07953	MONROE	227,292	22,049	0	0	7,757	194.03
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)	9,517,647	1,413,816	22,156	855,469	131,271	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/26/2017 12:15 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	BIO-MEDICAL						7.01
7.02	00702	UTILITIES - HOSPITAL						7.02
7.03	00703	UTILITIES - OFFSITE BLDGS						7.03
8.00	00800	LAUNDRY & LINEN SERVICE	336,058					8.00
9.00	00900	HOUSEKEEPING	50,263	1,098,829				9.00
10.00	01000	DIETARY	2,500	13,004	404,753			10.00
11.00	01100	CAFETERIA	11,474	59,688	0	1,260,975		11.00
13.00	01300	NURSING ADMINISTRATION	0	6,136	0	52,121	1,447,101	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	17,206	0	31,180	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26,541	0	35,167	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,986	176,031	267,391	176,197	506,887	30.00
31.00	03100	INTENSIVE CARE UNIT	11,273	32,938	28,065	60,242	173,310	31.00
40.00	04000	SUBPROVIDER - IPF	7,385	74,730	109,297	75,103	216,060	40.00
43.00	04300	NURSERY	19,807	17,499	0	14,859	42,746	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	48,865	114,619	0	99,069	285,009	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,024	12,418	0	10,545	30,338	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,083	92,563	0	92,689	0	54.00
60.00	06000	LABORATORY	139	41,039	0	104,771	0	60.00
65.00	06500	RESPIRATORY THERAPY	9,470	42,743	0	61,563	0	65.00
66.00	06600	PHYSICAL THERAPY	20,441	36,325	0	43,683	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,045	0	58,784	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	523	0	6,361	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	2,765	4,181	0	24,040	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,256	45,848	0	43,725	0	90.00
90.01	09001	CLINIC - AMO	36	20,436	0	27,305	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	6,127	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	734	24,304	0	18,452	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	327	9,021	0	1,638	0	90.04
91.00	09100	EMERGENCY	46,064	58,120	0	67,000	192,751	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	14,472	45,189	0	98,123	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	333,364	972,147	404,753	1,208,744	1,447,101	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,836	0	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	1,148	72,660	0	52,231	0	194.01
194.02	07952	OTHER MOBS	627	29,269	0	0	0	194.02
194.03	07953	MONROE	919	17,917	0	0	0	194.03
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)	336,058	1,098,829	404,753	1,260,975	1,447,101	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/26/2017 12:15 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	BIO-MEDICAL						7.01
7.02	00702	UTILITIES - HOSPITAL						7.02
7.03	00703	UTILITIES - OFFSITE BLDGS						7.03
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0					14.00
15.00	01500	PHARMACY	0	1,673,089				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,616,826			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	531,977	5,849,796	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	34,142	1,526,592	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	105,449	2,145,882	0	40.00
43.00	04300	NURSERY	0	0	3,079	501,353	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	150,841	3,957,737	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	2,185	392,653	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	21,194	3,512,106	0	54.00
60.00	06000	LABORATORY	0	0	0	4,514,493	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	14,607	1,394,740	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,633,026	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	531,869	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	308,267	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,284,642	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,673,089	0	2,897,588	0	73.00
76.00	03020	OP PSYCH	0	0	34,815	659,251	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	4,535	1,036,983	0	90.00
90.01	09001	CLINIC - AMO	0	0	6,178	803,230	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	808	366,948	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	2,961	515,861	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	746	121,041	0	90.04
91.00	09100	EMERGENCY	0	0	688,057	3,256,946	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	2,361,042	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,673,089	1,601,574	40,572,046	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	38,455	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	12,002	1,822,083	0	194.01
194.02	07952	OTHER MOBS	0	0	1,230	1,082,680	0	194.02
194.03	07953	MONROE	0	0	2,020	1,116,518	0	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,673,089	1,616,826	44,631,782	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/26/2017 12:15 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	BIO-MEDICAL			7.01
7.02	00702	UTILITIES - HOSPITAL			7.02
7.03	00703	UTILITIES - OFFSITE BLDGS			7.03
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	5,849,796		30.00
31.00	03100	INTENSIVE CARE UNIT	1,526,592		31.00
40.00	04000	SUBPROVIDER - IPF	2,145,882		40.00
43.00	04300	NURSERY	501,353		43.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	3,957,737		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	392,653		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,512,106		54.00
60.00	06000	LABORATORY	4,514,493		60.00
65.00	06500	RESPIRATORY THERAPY	1,394,740		65.00
66.00	06600	PHYSICAL THERAPY	1,633,026		66.00
67.00	06700	OCCUPATIONAL THERAPY	531,869		67.00
68.00	06800	SPEECH PATHOLOGY	308,267		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,284,642		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,897,588		73.00
76.00	03020	OP PSYCH	659,251		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	1,036,983		90.00
90.01	09001	CLINIC - AMO	803,230		90.01
90.02	09002	CLINIC - AMH NEURO	366,948		90.02
90.03	09003	CLINIC - NIGLIAZZO	515,861		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	121,041		90.04
91.00	09100	EMERGENCY	3,256,946		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	2,361,042		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		97.00
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	40,572,046		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	38,455		190.00
194.00	07950	TITLE XX	0		194.00
194.01	07951	OTHER NRCC	1,822,083		194.01
194.02	07952	OTHER MOBS	1,082,680		194.02
194.03	07953	MONROE	1,116,518		194.03
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	44,631,782		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/26/2017 12:15 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	236,805	0	236,805	0	5.00
7.00	00700	OPERATION OF PLANT	0	360,811	0	360,811	0	7.00
7.01	00701	BIO-MEDICAL	0	6,129	0	6,129	0	7.01
7.02	00702	UTILITIES - HOSPITAL	0	0	0	0	0	7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	34,858	0	34,858	0	8.00
9.00	00900	HOUSEKEEPING	0	47,458	0	47,458	0	9.00
10.00	01000	DIETARY	0	25,080	0	25,080	0	10.00
11.00	01100	CAFETERIA	0	115,117	0	115,117	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	11,834	0	11,834	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	33,184	0	33,184	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	51,188	0	51,188	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	339,503	0	339,503	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	63,526	0	63,526	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	144,128	0	144,128	0	40.00
43.00	04300	NURSERY	0	33,749	0	33,749	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	221,060	0	221,060	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	23,951	0	23,951	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	178,521	0	178,521	0	54.00
60.00	06000	LABORATORY	0	64,756	0	64,756	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	82,436	0	82,436	0	65.00
66.00	06600	PHYSICAL THERAPY	0	70,058	0	70,058	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,016	0	2,016	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,008	0	1,008	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	17,399	0	17,399	0	90.04
91.00	09100	EMERGENCY	0	112,092	0	112,092	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,276,667	0	2,276,667	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,185	0	13,185	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	63,445	0	63,445	0	194.01
194.02	07952	OTHER MOBS	0	0	0	0	0	194.02
194.03	07953	MONROE	0	0	0	0	0	194.03
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	2,353,297	0	2,353,297	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/26/2017 12:15 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	BIO-MEDICAL	UTILITIES - HOSPITAL	UTILITIES - OFFSITE BLDGS	
			5.00	7.00	7.01	7.02	7.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	236,805					5.00
7.00	00700	OPERATION OF PLANT	7,501	368,312				7.00
7.01	00701	BIO-MEDICAL	97	1,019	7,245			7.01
7.02	00702	UTILITIES - HOSPITAL	4,539	0	0	4,539		7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	697	0	0	0	697	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	1,575	5,794	0	90	0	8.00
9.00	00900	HOUSEKEEPING	5,252	9,223	21	123	0	9.00
10.00	01000	DIETARY	1,915	4,169	2	65	0	10.00
11.00	01100	CAFETERIA	5,624	19,135	11	299	0	11.00
13.00	01300	NURSING ADMINISTRATION	7,298	1,967	0	31	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	8,422	5,516	14	86	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,945	8,509	0	133	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,963	56,435	1,060	879	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,916	10,560	37	165	0	31.00
40.00	04000	SUBPROVIDER - IPF	7,404	23,958	9	374	0	40.00
43.00	04300	NURSERY	1,937	5,610	89	88	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,945	36,746	1,643	574	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,602	3,981	59	62	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,239	29,675	3,186	463	0	54.00
60.00	06000	LABORATORY	22,734	13,157	302	168	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,220	13,703	358	214	0	65.00
66.00	06600	PHYSICAL THERAPY	7,711	11,645	122	182	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,493	335	0	5	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,593	168	0	3	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,122	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,497	0	0	0	0	73.00
76.00	03020	OP PSYCH	3,121	1,340	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,691	14,698	3	0	0	90.00
90.01	09001	CLINIC - AMO	3,800	6,552	0	0	42	90.01
90.02	09002	CLINIC - AMH NEURO	1,910	0	11	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	2,332	7,792	23	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	476	2,892	0	45	0	90.04
91.00	09100	EMERGENCY	11,028	18,633	54	291	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	11,339	14,487	227	0	52	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	217,938	327,699	7,231	4,340	94	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	89	2,192	0	34	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	8,210	23,294	14	165	86	194.01
194.02	07952	OTHER MOBS	4,913	9,383	0	0	476	194.02
194.03	07953	MONROE	5,655	5,744	0	0	41	194.03
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)	236,805	368,312	7,245	4,539	697	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/26/2017 12:15 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	BIO-MEDICAL						7.01
7.02	00702	UTILITIES - HOSPITAL						7.02
7.03	00703	UTILITIES - OFFSITE BLDGS						7.03
8.00	00800	LAUNDRY & LINEN SERVICE	42,317					8.00
9.00	00900	HOUSEKEEPING	6,331	68,408				9.00
10.00	01000	DIETARY	315	810	32,356			10.00
11.00	01100	CAFETERIA	1,445	3,716	0	145,347		11.00
13.00	01300	NURSING ADMINISTRATION	0	382	0	6,008	27,520	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	1,071	0	3,594	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,652	0	4,054	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,413	10,960	21,376	20,309	9,639	30.00
31.00	03100	INTENSIVE CARE UNIT	1,419	2,051	2,243	6,944	3,296	31.00
40.00	04000	SUBPROVIDER - IPF	930	4,652	8,737	8,657	4,109	40.00
43.00	04300	NURSERY	2,494	1,089	0	1,713	813	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,153	7,136	0	11,419	5,420	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,010	773	0	1,216	577	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,292	5,763	0	10,684	0	54.00
60.00	06000	LABORATORY	18	2,555	0	12,076	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,192	2,661	0	7,096	0	65.00
66.00	06600	PHYSICAL THERAPY	2,574	2,261	0	5,035	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	65	0	6,776	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	33	0	733	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	348	260	0	2,771	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	284	2,854	0	5,040	0	90.00
90.01	09001	CLINIC - AMO	4	1,272	0	3,147	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	706	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	92	1,513	0	2,127	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	41	562	0	189	0	90.04
91.00	09100	EMERGENCY	5,800	3,618	0	7,723	3,666	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,822	2,813	0	11,310	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	41,977	60,522	32,356	139,327	27,520	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	426	0	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	145	4,523	0	6,020	0	194.01
194.02	07952	OTHER MOBS	79	1,822	0	0	0	194.02
194.03	07953	MONROE	116	1,115	0	0	0	194.03
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)	42,317	68,408	32,356	145,347	27,520	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/26/2017 12:15 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	BIO-MEDICAL						7.01
7.02	00702	UTILITIES - HOSPITAL						7.02
7.03	00703	UTILITIES - OFFSITE BLDGS						7.03
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0					14.00
15.00	01500	PHARMACY	0	51,887				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	73,481			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	24,177	509,714	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	1,552	97,709	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,792	207,750	0	40.00
43.00	04300	NURSERY	0	0	140	47,722	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	6,855	312,951	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	99	33,330	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	963	249,786	0	54.00
60.00	06000	LABORATORY	0	0	0	115,766	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	664	114,544	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	99,588	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	11,690	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,538	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	12,122	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	51,887	0	58,384	0	73.00
76.00	03020	OP PSYCH	0	0	1,582	9,422	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	206	27,776	0	90.00
90.01	09001	CLINIC - AMO	0	0	281	15,098	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	37	2,664	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	135	14,014	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	34	21,638	0	90.04
91.00	09100	EMERGENCY	0	0	31,271	194,176	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	42,050	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	51,887	72,788	2,201,432	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	15,926	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	545	106,447	0	194.01
194.02	07952	OTHER MOBS	0	0	56	16,729	0	194.02
194.03	07953	MONROE	0	0	92	12,763	0	194.03
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	51,887	73,481	2,353,297	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/26/2017 12:15 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	BIO-MEDICAL			7.01
7.02	00702	UTILITIES - HOSPITAL			7.02
7.03	00703	UTILITIES - OFFSITE BLDGS			7.03
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	509,714		30.00
31.00	03100	INTENSIVE CARE UNIT	97,709		31.00
40.00	04000	SUBPROVIDER - IPF	207,750		40.00
43.00	04300	NURSERY	47,722		43.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	312,951		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,330		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	249,786		54.00
60.00	06000	LABORATORY	115,766		60.00
65.00	06500	RESPIRATORY THERAPY	114,544		65.00
66.00	06600	PHYSICAL THERAPY	99,588		66.00
67.00	06700	OCCUPATIONAL THERAPY	11,690		67.00
68.00	06800	SPEECH PATHOLOGY	3,538		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,122		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,384		73.00
76.00	03020	OP PSYCH	9,422		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	27,776		90.00
90.01	09001	CLINIC - AMO	15,098		90.01
90.02	09002	CLINIC - AMH NEURO	2,664		90.02
90.03	09003	CLINIC - NIGLIAZZO	14,014		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	21,638		90.04
91.00	09100	EMERGENCY	194,176		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	42,050		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		97.00
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,201,432		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,926		190.00
194.00	07950	TITLE XX	0		194.00
194.01	07951	OTHER NRCC	106,447		194.01
194.02	07952	OTHER MOBS	16,729		194.02
194.03	07953	MONROE	12,763		194.03
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	2,353,297		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/26/2017 12:15 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	116,728					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	25,035,880			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,746	0	1,983,960	-9,517,647	35,114,135	5.00
7.00	00700	OPERATION OF PLANT	17,897	0	183,004	0	1,112,322	7.00
7.01	00701	BIO-MEDICAL	304	0	3,518	0	14,354	7.01
7.02	00702	UTILITIES - HOSPITAL	0	0	0	0	673,042	7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	0	0	0	0	103,278	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	1,729	0	43,966	0	233,486	8.00
9.00	00900	HOUSEKEEPING	2,354	0	437,869	0	778,802	9.00
10.00	01000	DIETARY	1,244	0	123,634	0	283,998	10.00
11.00	01100	CAFETERIA	5,710	0	567,452	0	833,985	11.00
13.00	01300	NURSING ADMINISTRATION	587	0	843,588	0	1,082,182	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,646	0	721,117	0	1,248,780	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,539	0	395,414	0	1,178,103	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,840	0	2,518,833	0	2,960,115	30.00
31.00	03100	INTENSIVE CARE UNIT	3,151	0	590,494	0	877,159	31.00
40.00	04000	SUBPROVIDER - IPF	7,149	0	795,561	0	1,097,829	40.00
43.00	04300	NURSERY	1,674	0	185,464	0	287,208	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,965	0	2,516,270	0	2,364,322	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,188	0	131,620	0	237,573	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,855	0	1,018,844	0	2,407,950	54.00
60.00	06000	LABORATORY	3,212	0	1,042,939	0	3,371,589	60.00
65.00	06500	RESPIRATORY THERAPY	4,089	0	647,774	0	922,351	65.00
66.00	06600	PHYSICAL THERAPY	3,475	0	789,050	0	1,143,343	66.00
67.00	06700	OCCUPATIONAL THERAPY	100	0	267,444	0	369,591	67.00
68.00	06800	SPEECH PATHOLOGY	50	0	178,590	0	236,220	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,797,446	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	963,377	73.00
76.00	03020	OP PSYCH	0	0	329,248	0	462,849	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	1,039,404	0	695,637	90.00
90.01	09001	CLINIC - AMO	0	0	1,098,398	0	563,435	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	240,764	0	283,213	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	1,116,147	0	345,723	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	863	0	18,192	0	70,572	90.04
91.00	09100	EMERGENCY	5,560	0	2,399,109	0	1,635,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	1,129,980	0	1,681,364	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	112,927	0	23,357,647	-9,517,647	32,316,426	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	654	0	0	0	13,185	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	3,147	0	741,842	0	1,217,438	194.01
194.02	07952	OTHER MOBS	0	0	385,197	0	728,522	194.02
194.03	07953	MONROE	0	0	551,194	0	838,564	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,353,297	0	18,988		9,517,647	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.160518	0.000000	0.000758		0.271049	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		236,805	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.006744	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/26/2017 12:15 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	BIO-MEDICAL (COST)	UTILITIES - HOSPITAL (SQUARE FEET)	UTILITIES - OFFSITE BLDGS (COST)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			7.00	7.01	7.02	7.03	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	109,904					7.00
7.01	00701	BIO-MEDICAL	304	15,528,021				7.01
7.02	00702	UTILITIES - HOSPITAL	0	0	86,781			7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	0	0	0	108,744		7.03
8.00	00800	LAUNDRY & LINEN SERVICE	1,729	0	1,729	0	207,314	8.00
9.00	00900	HOUSEKEEPING	2,752	43,924	2,354	0	31,006	9.00
10.00	01000	DIETARY	1,244	5,290	1,244	0	1,542	10.00
11.00	01100	CAFETERIA	5,710	24,281	5,710	0	7,078	11.00
13.00	01300	NURSING ADMINISTRATION	587	0	587	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,646	29,461	1,646	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,539	0	2,539	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,840	2,269,592	16,840	0	26,518	30.00
31.00	03100	INTENSIVE CARE UNIT	3,151	79,410	3,151	0	6,954	31.00
40.00	04000	SUBPROVIDER - IPF	7,149	18,226	7,149	0	4,556	40.00
43.00	04300	NURSERY	1,674	190,204	1,674	0	12,219	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,965	3,517,140	10,965	0	30,145	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,188	127,243	1,188	0	4,950	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,855	6,837,239	8,855	0	21,026	54.00
60.00	06000	LABORATORY	3,926	647,436	3,212	0	86	60.00
65.00	06500	RESPIRATORY THERAPY	4,089	766,651	4,089	0	5,842	65.00
66.00	06600	PHYSICAL THERAPY	3,475	261,153	3,475	0	12,610	66.00
67.00	06700	OCCUPATIONAL THERAPY	100	0	100	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	50	0	50	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	400	0	0	0	1,706	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,386	5,551	0	0	1,392	90.00
90.01	09001	CLINIC - AMO	1,955	0	0	6,605	22	90.01
90.02	09002	CLINIC - AMH NEURO	0	24,275	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	2,325	49,167	0	0	453	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	863	0	863	0	202	90.04
91.00	09100	EMERGENCY	5,560	116,271	5,560	0	28,417	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,323	486,411	0	8,165	8,928	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	97,785	15,498,925	82,980	14,770	205,652	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	654	0	654	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	6,951	29,096	3,147	13,368	708	194.01
194.02	07952	OTHER MOBS	2,800	0	0	74,180	387	194.02
194.03	07953	MONROE	1,714	0	0	6,426	567	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,413,816	22,156	855,469	131,271	336,058	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.864100	0.001427	9.857791	1.207156	1.621010	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	368,312	7,245	4,539	697	42,317	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.351216	0.000467	0.052304	0.006410	0.204120	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/26/2017 12:15 pm

		Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	BIO-MEDICAL						7.01
7.02	00702	UTILITIES - HOSPITAL						7.02
7.03	00703	UTILITIES - OFFSITE BLDGS						7.03
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	105,119					9.00
10.00	01000	DIETARY	1,244	17,220				10.00
11.00	01100	CAFETERIA	5,710	0	722,121			11.00
13.00	01300	NURSING ADMINISTRATION	587	0	29,848	288,060		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,646	0	17,856	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,539	0	20,139	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,840	11,376	100,901	100,901	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,151	1,194	34,499	34,499	0	31.00
40.00	04000	SUBPROVIDER - IPF	7,149	4,650	43,009	43,009	0	40.00
43.00	04300	NURSERY	1,674	0	8,509	8,509	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,965	0	56,734	56,734	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,188	0	6,039	6,039	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,855	0	53,080	0	0	54.00
60.00	06000	LABORATORY	3,926	0	59,999	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,089	0	35,255	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,475	0	25,016	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	100	0	33,664	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	50	0	3,643	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	400	0	13,767	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,386	0	25,040	0	0	90.00
90.01	09001	CLINIC - AMO	1,955	0	15,637	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	3,509	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	2,325	0	10,567	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	863	0	938	0	0	90.04
91.00	09100	EMERGENCY	5,560	0	38,369	38,369	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,323	0	56,192	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	93,000	17,220	692,210	288,060	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	654	0	0	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	6,951	0	29,911	0	0	194.01
194.02	07952	OTHER MOBS	2,800	0	0	0	0	194.02
194.03	07953	MONROE	1,714	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,098,829	404,753	1,260,975	1,447,101	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.453191	23.504820	1.746210	5.023610	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	68,408	32,356	145,347	27,520	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.650767	1.878978	0.201278	0.095536	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/26/2017 12:15 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			15.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	BIO-MEDICAL				7.01
7.02	00702	UTILITIES - HOSPITAL				7.02
7.03	00703	UTILITIES - OFFSITE BLDGS				7.03
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,385,235		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	455,778		30.00
31.00	03100	INTENSIVE CARE UNIT	0	29,252		31.00
40.00	04000	SUBPROVIDER - IPF	0	90,345		40.00
43.00	04300	NURSERY	0	2,638		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	129,235		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,872		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,158		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	12,515		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	0		73.00
76.00	03020	OP PSYCH	0	29,828		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	3,885		90.00
90.01	09001	CLINIC - AMO	0	5,293		90.01
90.02	09002	CLINIC - AMH NEURO	0	692		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	2,537		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	639		90.04
91.00	09100	EMERGENCY	0	589,500		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	1,372,167		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	TITLE XX	0	0		194.00
194.01	07951	OTHER NRCC	0	10,283		194.01
194.02	07952	OTHER MOBS	0	1,054		194.02
194.03	07953	MONROE	0	1,731		194.03
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,673,089	1,616,826		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16,730.890000	1.167185		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	51,887	73,481		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	518.870000	0.053046		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,849,796		5,849,796	0	5,849,796	30.00
31.00	03100	INTENSIVE CARE UNIT	1,526,592		1,526,592	0	1,526,592	31.00
40.00	04000	SUBPROVIDER - IPF	2,145,882		2,145,882	0	2,145,882	40.00
43.00	04300	NURSERY	501,353		501,353	0	501,353	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,957,737		3,957,737	0	3,957,737	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	392,653		392,653	0	392,653	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,512,106		3,512,106	0	3,512,106	54.00
60.00	06000	LABORATORY	4,514,493		4,514,493	0	4,514,493	60.00
65.00	06500	RESPIRATORY THERAPY	1,394,740	0	1,394,740	0	1,394,740	65.00
66.00	06600	PHYSICAL THERAPY	1,633,026	0	1,633,026	0	1,633,026	66.00
67.00	06700	OCCUPATIONAL THERAPY	531,869	0	531,869	0	531,869	67.00
68.00	06800	SPEECH PATHOLOGY	308,267	0	308,267	0	308,267	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,284,642		2,284,642	0	2,284,642	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,897,588		2,897,588	0	2,897,588	73.00
76.00	03020	OP PSYCH	659,251		659,251	0	659,251	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,036,983		1,036,983	0	1,036,983	90.00
90.01	09001	CLINIC - AMO	803,230		803,230	0	803,230	90.01
90.02	09002	CLINIC - AMH NEURO	366,948		366,948	0	366,948	90.02
90.03	09003	CLINIC - NIGLIAZZO	515,861		515,861	0	515,861	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	121,041		121,041	0	121,041	90.04
91.00	09100	EMERGENCY	3,256,946		3,256,946	0	3,256,946	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,463,374		1,463,374		1,463,374	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,361,042		2,361,042	0	2,361,042	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	42,035,420	0	42,035,420	0	42,035,420	200.00
201.00		Less Observation Beds	1,463,374		1,463,374		1,463,374	201.00
202.00		Total (see instructions)	40,572,046	0	40,572,046	0	40,572,046	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,751,120		4,751,120			30.00
31.00	03100	INTENSIVE CARE UNIT	831,615		831,615			31.00
40.00	04000	SUBPROVIDER - IPF	2,077,227		2,077,227			40.00
43.00	04300	NURSERY	246,598		246,598			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,467,058	5,768,979	7,236,037	0.546948	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	126,202	48,806	175,008	2.243629	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,470,666	17,675,040	19,145,706	0.183441	0.000000	54.00
60.00	06000	LABORATORY	2,862,285	15,310,360	18,172,645	0.248422	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,623,015	2,658,487	5,281,502	0.264080	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	485,340	3,177,252	3,662,592	0.445866	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	380,653	576,537	957,190	0.555657	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	109,139	545,891	655,030	0.470615	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,830,027	1,255,141	3,085,168	0.740524	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,130,883	6,002,906	10,133,789	0.285933	0.000000	73.00
76.00	03020	OP PSYCH	0	685,808	685,808	0.961276	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	361	2,423,475	2,423,836	0.427827	0.000000	90.00
90.01	09001	CLINIC - AMO	0	3,302,292	3,302,292	0.243234	0.000000	90.01
90.02	09002	CLINIC - AMH NEURO	0	431,681	431,681	0.850044	0.000000	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	1,583,025	1,583,025	0.325870	0.000000	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	14,700	14,700	8.234082	0.000000	90.04
91.00	09100	EMERGENCY	187,875	2,502,490	2,690,365	1.210596	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	28,134	2,170,297	2,198,431	0.665645	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,611,322	2,611,322	0.904156	0.000000	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	23,608,198	68,744,489	92,352,687			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	23,608,198	68,744,489	92,352,687			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.546948		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.243629		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.183441		54.00
60.00	06000	LABORATORY	0.248422		60.00
65.00	06500	RESPIRATORY THERAPY	0.264080		65.00
66.00	06600	PHYSICAL THERAPY	0.445866		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.555657		67.00
68.00	06800	SPEECH PATHOLOGY	0.470615		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.740524		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285933		73.00
76.00	03020	OP PSYCH	0.961276		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.427827		90.00
90.01	09001	CLINIC - AMO	0.243234		90.01
90.02	09002	CLINIC - AMH NEURO	0.850044		90.02
90.03	09003	CLINIC - NIGLIAZZO	0.325870		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	8.234082		90.04
91.00	09100	EMERGENCY	1.210596		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.665645		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.904156		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
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: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/26/2017 12:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,849,796		5,849,796	0	5,849,796	30.00
31.00	03100	INTENSIVE CARE UNIT	1,526,592		1,526,592	0	1,526,592	31.00
40.00	04000	SUBPROVIDER - IPF	2,145,882		2,145,882	0	2,145,882	40.00
43.00	04300	NURSERY	501,353		501,353	0	501,353	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,957,737		3,957,737	0	3,957,737	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	392,653		392,653	0	392,653	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,512,106		3,512,106	0	3,512,106	54.00
60.00	06000	LABORATORY	4,514,493		4,514,493	0	4,514,493	60.00
65.00	06500	RESPIRATORY THERAPY	1,394,740	0	1,394,740	0	1,394,740	65.00
66.00	06600	PHYSICAL THERAPY	1,633,026	0	1,633,026	0	1,633,026	66.00
67.00	06700	OCCUPATIONAL THERAPY	531,869	0	531,869	0	531,869	67.00
68.00	06800	SPEECH PATHOLOGY	308,267	0	308,267	0	308,267	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,284,642		2,284,642	0	2,284,642	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,897,588		2,897,588	0	2,897,588	73.00
76.00	03020	OP PSYCH	659,251		659,251	0	659,251	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,036,983		1,036,983	0	1,036,983	90.00
90.01	09001	CLINIC - AMO	803,230		803,230	0	803,230	90.01
90.02	09002	CLINIC - AMH NEURO	366,948		366,948	0	366,948	90.02
90.03	09003	CLINIC - NIGLIAZZO	515,861		515,861	0	515,861	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	121,041		121,041	0	121,041	90.04
91.00	09100	EMERGENCY	3,256,946		3,256,946	0	3,256,946	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,463,374		1,463,374		1,463,374	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,361,042		2,361,042	0	2,361,042	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	42,035,420	0	42,035,420	0	42,035,420	200.00
201.00		Less Observation Beds	1,463,374		1,463,374		1,463,374	201.00
202.00		Total (see instructions)	40,572,046	0	40,572,046	0	40,572,046	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/26/2017 12:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,751,120		4,751,120			30.00
31.00	03100	INTENSIVE CARE UNIT	831,615		831,615			31.00
40.00	04000	SUBPROVIDER - IPF	2,077,227		2,077,227			40.00
43.00	04300	NURSERY	246,598		246,598			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,467,058	5,768,979	7,236,037	0.546948	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	126,202	48,806	175,008	2.243629	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,470,666	17,675,040	19,145,706	0.183441	0.000000	54.00
60.00	06000	LABORATORY	2,862,285	15,310,360	18,172,645	0.248422	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,623,015	2,658,487	5,281,502	0.264080	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	485,340	3,177,252	3,662,592	0.445866	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	380,653	576,537	957,190	0.555657	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	109,139	545,891	655,030	0.470615	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,830,027	1,255,141	3,085,168	0.740524	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,130,883	6,002,906	10,133,789	0.285933	0.000000	73.00
76.00	03020	OP PSYCH	0	685,808	685,808	0.961276	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	361	2,423,475	2,423,836	0.427827	0.000000	90.00
90.01	09001	CLINIC - AMO	0	3,302,292	3,302,292	0.243234	0.000000	90.01
90.02	09002	CLINIC - AMH NEURO	0	431,681	431,681	0.850044	0.000000	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	1,583,025	1,583,025	0.325870	0.000000	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	14,700	14,700	8.234082	0.000000	90.04
91.00	09100	EMERGENCY	187,875	2,502,490	2,690,365	1.210596	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	28,134	2,170,297	2,198,431	0.665645	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,611,322	2,611,322	0.904156	0.000000	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	23,608,198	68,744,489	92,352,687			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	23,608,198	68,744,489	92,352,687			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/26/2017 12:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.546948	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.243629	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.183441	54.00
60.00	06000	LABORATORY	0.248422	60.00
65.00	06500	RESPIRATORY THERAPY	0.264080	65.00
66.00	06600	PHYSICAL THERAPY	0.445866	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.555657	67.00
68.00	06800	SPEECH PATHOLOGY	0.470615	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.740524	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285933	73.00
76.00	03020	OP PSYCH	0.961276	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.427827	90.00
90.01	09001	CLINIC - AMO	0.243234	90.01
90.02	09002	CLINIC - AMH NEURO	0.850044	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.325870	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	8.234082	90.04
91.00	09100	EMERGENCY	1.210596	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.665645	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.904156	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part II Date/Time Prepared: 5/26/2017 12:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,957,737	312,951	3,644,786	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	392,653	33,330	359,323	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,512,106	249,786	3,262,320	0	0	54.00
60.00	06000	LABORATORY	4,514,493	115,766	4,398,727	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,394,740	114,544	1,280,196	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,633,026	99,588	1,533,438	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	531,869	11,690	520,179	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	308,267	3,538	304,729	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,284,642	12,122	2,272,520	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,897,588	58,384	2,839,204	0	0	73.00
76.00	03020	OP PSYCH	659,251	9,422	649,829	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,036,983	27,776	1,009,207	0	0	90.00
90.01	09001	CLINIC - AMO	803,230	15,098	788,132	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	366,948	2,664	364,284	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	515,861	14,014	501,847	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	121,041	21,638	99,403	0	0	90.04
91.00	09100	EMERGENCY	3,256,946	194,176	3,062,770	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,463,374	127,510	1,335,864	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,361,042	42,050	2,318,992	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	32,011,797	1,466,047	30,545,750	0	0	200.00
201.00		Less Observation Beds	1,463,374	127,510	1,335,864	0	0	201.00
202.00		Total (line 200 minus line 201)	30,548,423	1,338,537	29,209,886	0	0	202.00

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

Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part II Date/Time Prepared: 5/26/2017 12:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,957,737	7,236,037	0.546948		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	392,653	175,008	2.243629		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,512,106	19,145,706	0.183441		54.00
60.00	06000	LABORATORY	4,514,493	18,172,645	0.248422		60.00
65.00	06500	RESPIRATORY THERAPY	1,394,740	5,281,502	0.264080		65.00
66.00	06600	PHYSICAL THERAPY	1,633,026	3,662,592	0.445866		66.00
67.00	06700	OCCUPATIONAL THERAPY	531,869	957,190	0.555657		67.00
68.00	06800	SPEECH PATHOLOGY	308,267	655,030	0.470615		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,284,642	3,085,168	0.740524		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,897,588	10,133,789	0.285933		73.00
76.00	03020	OP PSYCH	659,251	685,808	0.961276		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,036,983	2,423,836	0.427827		90.00
90.01	09001	CLINIC - AMO	803,230	3,302,292	0.243234		90.01
90.02	09002	CLINIC - AMH NEURO	366,948	431,681	0.850044		90.02
90.03	09003	CLINIC - NIGLIAZZO	515,861	1,583,025	0.325870		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	121,041	14,700	8.234082		90.04
91.00	09100	EMERGENCY	3,256,946	2,690,365	1.210596		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,463,374	2,198,431	0.665645		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	2,361,042	2,611,322	0.904156		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000		97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0.000000		116.00
200.00		Subtotal (sum of lines 50 thru 199)	32,011,797	84,446,127			200.00
201.00		Less Observation Beds	1,463,374	0			201.00
202.00		Total (line 200 minus line 201)	30,548,423	84,446,127			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	312,951	7,236,037	0.043249	124,510	5,385	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,330	175,008	0.190448	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	249,786	19,145,706	0.013047	439,165	5,730	54.00
60.00	06000	LABORATORY	115,766	18,172,645	0.006370	1,137,477	7,246	60.00
65.00	06500	RESPIRATORY THERAPY	114,544	5,281,502	0.021688	1,247,039	27,046	65.00
66.00	06600	PHYSICAL THERAPY	99,588	3,662,592	0.027191	157,402	4,280	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,690	957,190	0.012213	112,247	1,371	67.00
68.00	06800	SPEECH PATHOLOGY	3,538	655,030	0.005401	58,908	318	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,122	3,085,168	0.003929	996,367	3,915	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,384	10,133,789	0.005761	1,433,426	8,258	73.00
76.00	03020	OP PSYCH	9,422	685,808	0.013739	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	27,776	2,423,836	0.011460	361	4	90.00
90.01	09001	CLINIC - AMO	15,098	3,302,292	0.004572	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	2,664	431,681	0.006171	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	14,014	1,583,025	0.008853	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	21,638	14,700	1.471973	0	0	90.04
91.00	09100	EMERGENCY	194,176	2,690,365	0.072175	4,738	342	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	127,510	2,198,431	0.058000	28,134	1,632	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50-199)	1,423,997	81,834,805		5,739,774	65,527	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
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: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,236,037	0.000000	0.000000	124,510	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	175,008	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,145,706	0.000000	0.000000	439,165	54.00
60.00	06000	LABORATORY	0	18,172,645	0.000000	0.000000	1,137,477	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,281,502	0.000000	0.000000	1,247,039	65.00
66.00	06600	PHYSICAL THERAPY	0	3,662,592	0.000000	0.000000	157,402	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	957,190	0.000000	0.000000	112,247	67.00
68.00	06800	SPEECH PATHOLOGY	0	655,030	0.000000	0.000000	58,908	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,085,168	0.000000	0.000000	996,367	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,133,789	0.000000	0.000000	1,433,426	73.00
76.00	03020	OP PSYCH	0	685,808	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,423,836	0.000000	0.000000	361	90.00
90.01	09001	CLINIC - AMO	0	3,302,292	0.000000	0.000000	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	431,681	0.000000	0.000000	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	1,583,025	0.000000	0.000000	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	14,700	0.000000	0.000000	0	90.04
91.00	09100	EMERGENCY	0	2,690,365	0.000000	0.000000	4,738	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,198,431	0.000000	0.000000	28,134	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
200.00		Total (lines 50-199)	0	81,834,805			5,739,774	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	OP PSYCH	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	CLINIC - AMO	0	0	0		90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0		90.04
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.546948	0	1,245,147	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.243629	0	166	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.183441	0	3,923,326	0	0	54.00
60.00	06000	LABORATORY	0.248422	0	1,823,400	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.264080	0	1,381,754	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.445866	0	960,991	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.555657	0	94,334	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.470615	0	48,712	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.740524	0	1,057,294	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285933	0	1,630,921	5,401	0	73.00
76.00	03020	OP PSYCH	0.961276	0	64,879	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.427827	0	248,204	1,967	0	90.00
90.01	09001	CLINIC - AMO	0.243234	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.850044	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.325870	0	0	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	8.234082	0	0	0	0	90.04
91.00	09100	EMERGENCY	1.210596	0	528,018	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.665645	0	467,710	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.904156		0			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00		Subtotal (see instructions)		0	13,474,856	7,368	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	13,474,856	7,368	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	681,031	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	372	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	719,699	0		54.00
60.00	06000	LABORATORY	452,973	0		60.00
65.00	06500	RESPIRATORY THERAPY	364,894	0		65.00
66.00	06600	PHYSICAL THERAPY	428,473	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	52,417	0		67.00
68.00	06800	SPEECH PATHOLOGY	22,925	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	782,952	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	466,334	1,544		73.00
76.00	03020	OP PSYCH	62,367	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	106,188	842		90.00
90.01	09001	CLINIC - AMO	0	0		90.01
90.02	09002	CLINIC - AMH NEURO	0	0		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0		90.04
91.00	09100	EMERGENCY	639,216	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	311,329	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00		Subtotal (see instructions)	5,091,170	2,386		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,091,170	2,386		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1330 | Component CCN: 15-M330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	312,951	7,236,037	0.043249	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,330	175,008	0.190448	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	249,786	19,145,706	0.013047	14,026	183	54.00
60.00	06000	LABORATORY	115,766	18,172,645	0.006370	51,301	327	60.00
65.00	06500	RESPIRATORY THERAPY	114,544	5,281,502	0.021688	16,909	367	65.00
66.00	06600	PHYSICAL THERAPY	99,588	3,662,592	0.027191	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,690	957,190	0.012213	180	2	67.00
68.00	06800	SPEECH PATHOLOGY	3,538	655,030	0.005401	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,122	3,085,168	0.003929	6,197	24	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,384	10,133,789	0.005761	105,398	607	73.00
76.00	03020	OP PSYCH	9,422	685,808	0.013739	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	27,776	2,423,836	0.011460	0	0	90.00
90.01	09001	CLINIC - AMO	15,098	3,302,292	0.004572	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	2,664	431,681	0.006171	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	14,014	1,583,025	0.008853	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	21,638	14,700	1.471973	0	0	90.04
91.00	09100	EMERGENCY	194,176	2,690,365	0.072175	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,198,431	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50-199)	1,296,487	81,834,805		194,011	1,510	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1330 | Component CCN: 15-M330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
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: 15-1330 | Component CCN: 15-M330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,236,037	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	175,008	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,145,706	0.000000	0.000000	14,026	54.00
60.00	06000	LABORATORY	0	18,172,645	0.000000	0.000000	51,301	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,281,502	0.000000	0.000000	16,909	65.00
66.00	06600	PHYSICAL THERAPY	0	3,662,592	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	957,190	0.000000	0.000000	180	67.00
68.00	06800	SPEECH PATHOLOGY	0	655,030	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,085,168	0.000000	0.000000	6,197	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,133,789	0.000000	0.000000	105,398	73.00
76.00	03020	OP PSYCH	0	685,808	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,423,836	0.000000	0.000000	0	90.00
90.01	09001	CLINIC - AMO	0	3,302,292	0.000000	0.000000	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	431,681	0.000000	0.000000	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	1,583,025	0.000000	0.000000	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	14,700	0.000000	0.000000	0	90.04
91.00	09100	EMERGENCY	0	2,690,365	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,198,431	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
200.00		Total (lines 50-199)	0	81,834,805			194,011	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1330 | Component CCN: 15-M330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	OP PSYCH	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	CLINIC - AMO	0	0	0		90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0		90.04
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1330 | Component CCN: 15-Z330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.546948	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.243629	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.183441	0	0	0	0	54.00
60.00	06000	LABORATORY	0.248422	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.264080	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.445866	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.555657	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.470615	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.740524	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285933	0	0	0	0	73.00
76.00	03020	OP PSYCH	0.961276	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.427827	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0.243234	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.850044	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.325870	0	0	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	8.234082	0	0	0	0	90.04
91.00	09100	EMERGENCY	1.210596	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.665645	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.904156		0			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1330 | Component CCN: 15-Z330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V | Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	OP PSYCH	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC - AMO	0	0		90.01
90.02	09002	CLINIC - AMH NEURO	0	0		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0		90.04
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part I Date/Time Prepared: 5/26/2017 12:15 pm

Title XIX | 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	509,714	28,708	481,006	5,070	94.87	30.00
31.00	INTENSIVE CARE UNIT	97,709		97,709	398	245.50	31.00
40.00	SUBPROVIDER - IPF	207,750	0	207,750	1,550	134.03	40.00
43.00	NURSERY	47,722		47,722	380	125.58	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	862,895		834,187	7,398		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	171	16,223		30.00
31.00	INTENSIVE CARE UNIT	4	982		31.00
40.00	SUBPROVIDER - IPF	106	14,207		40.00
43.00	NURSERY	59	7,409		43.00
44.00	SKILLED NURSING FACILITY	0	0		44.00
200.00	Total (lines 30-199)	340	38,821		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/26/2017 12:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	312,951	7,236,037	0.043249	50,578	2,187	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,330	175,008	0.190448	30,643	5,836	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	249,786	19,145,706	0.013047	80,106	1,045	54.00
60.00	06000	LABORATORY	115,766	18,172,645	0.006370	254,468	1,621	60.00
65.00	06500	RESPIRATORY THERAPY	114,544	5,281,502	0.021688	109,399	2,373	65.00
66.00	06600	PHYSICAL THERAPY	99,588	3,662,592	0.027191	3,342	91	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,690	957,190	0.012213	1,797	22	67.00
68.00	06800	SPEECH PATHOLOGY	3,538	655,030	0.005401	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,122	3,085,168	0.003929	72,070	283	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,384	10,133,789	0.005761	368,231	2,121	73.00
76.00	03020	OP PSYCH	9,422	685,808	0.013739	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	27,776	2,423,836	0.011460	0	0	90.00
90.01	09001	CLINIC - AMO	15,098	3,302,292	0.004572	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	2,664	431,681	0.006171	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	14,014	1,583,025	0.008853	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	21,638	14,700	1.471973	0	0	90.04
91.00	09100	EMERGENCY	194,176	2,690,365	0.072175	38,904	2,808	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	127,510	2,198,431	0.058000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50-199)	1,423,997	81,834,805		1,009,538	18,387	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 5/26/2017 12:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0			0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,070	0.00	171	0		30.00
31.00	03100	INTENSIVE CARE UNIT	398	0.00	4	0		31.00
40.00	04000	SUBPROVIDER - IPF	1,550	0.00	106	0		40.00
43.00	04300	NURSERY	380	0.00	59	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	7,398		340	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/26/2017 12:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
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: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/26/2017 12:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,236,037	0.000000	0.000000	50,578	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	175,008	0.000000	0.000000	30,643	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,145,706	0.000000	0.000000	80,106	54.00
60.00	06000	LABORATORY	0	18,172,645	0.000000	0.000000	254,468	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,281,502	0.000000	0.000000	109,399	65.00
66.00	06600	PHYSICAL THERAPY	0	3,662,592	0.000000	0.000000	3,342	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	957,190	0.000000	0.000000	1,797	67.00
68.00	06800	SPEECH PATHOLOGY	0	655,030	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,085,168	0.000000	0.000000	72,070	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,133,789	0.000000	0.000000	368,231	73.00
76.00	03020	OP PSYCH	0	685,808	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,423,836	0.000000	0.000000	0	90.00
90.01	09001	CLINIC - AMO	0	3,302,292	0.000000	0.000000	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	431,681	0.000000	0.000000	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	1,583,025	0.000000	0.000000	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	14,700	0.000000	0.000000	0	90.04
91.00	09100	EMERGENCY	0	2,690,365	0.000000	0.000000	38,904	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,198,431	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
200.00		Total (lines 50-199)	0	81,834,805			1,009,538	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/26/2017 12:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	OP PSYCH	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	CLINIC - AMO	0	0	0		90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0		90.04
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1330 | Component CCN: 15-M330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/26/2017 12:15 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	312,951	7,236,037	0.043249	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,330	175,008	0.190448	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	249,786	19,145,706	0.013047	948	12	54.00
60.00	06000	LABORATORY	115,766	18,172,645	0.006370	37,653	240	60.00
65.00	06500	RESPIRATORY THERAPY	114,544	5,281,502	0.021688	10,171	221	65.00
66.00	06600	PHYSICAL THERAPY	99,588	3,662,592	0.027191	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,690	957,190	0.012213	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,538	655,030	0.005401	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,122	3,085,168	0.003929	2,683	11	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,384	10,133,789	0.005761	62,157	358	73.00
76.00	03020	OP PSYCH	9,422	685,808	0.013739	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	27,776	2,423,836	0.011460	0	0	90.00
90.01	09001	CLINIC - AMO	15,098	3,302,292	0.004572	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	2,664	431,681	0.006171	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	14,014	1,583,025	0.008853	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	21,638	14,700	1.471973	0	0	90.04
91.00	09100	EMERGENCY	194,176	2,690,365	0.072175	361	26	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,198,431	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50-199)	1,296,487	81,834,805		113,973	868	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1330 | Component CCN: 15-M330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/26/2017 12:15 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
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: 15-1330 | Component CCN: 15-M330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/26/2017 12:15 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,236,037	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	175,008	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,145,706	0.000000	0.000000	948	54.00
60.00	06000	LABORATORY	0	18,172,645	0.000000	0.000000	37,653	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,281,502	0.000000	0.000000	10,171	65.00
66.00	06600	PHYSICAL THERAPY	0	3,662,592	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	957,190	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	655,030	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,085,168	0.000000	0.000000	2,683	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,133,789	0.000000	0.000000	62,157	73.00
76.00	03020	OP PSYCH	0	685,808	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,423,836	0.000000	0.000000	0	90.00
90.01	09001	CLINIC - AMO	0	3,302,292	0.000000	0.000000	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	431,681	0.000000	0.000000	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	1,583,025	0.000000	0.000000	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	14,700	0.000000	0.000000	0	90.04
91.00	09100	EMERGENCY	0	2,690,365	0.000000	0.000000	361	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,198,431	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
200.00		Total (lines 50-199)	0	81,834,805			113,973	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1330 | Component CCN: 15-M330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/26/2017 12:15 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	OP PSYCH	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	CLINIC - AMO	0	0	0		90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0		90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	0	0	0		90.04
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,652	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,070	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)	3,726	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	265	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	317	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,594	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)	265	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	129.14	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)	5,849,796	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)	40,937	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)	329,474	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,520,322	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,520,322	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,088.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,735,579	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,735,579	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,526,592	398	3,835.66	200	767,132	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)	2,093,142	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,595,853	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)	288,537	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)	288,537	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,344	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,088.82	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,463,374	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	509,714	5,849,796	0.087134	1,463,374	127,510	90.00
91.00	Nursing School cost	0	5,849,796	0.000000	1,463,374	0	91.00
92.00	Allied health cost	0	5,849,796	0.000000	1,463,374	0	92.00
93.00	All other Medical Education	0	5,849,796	0.000000	1,463,374	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1330 Component CCN: 15-M330	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/26/2017 12:15 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,550	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,550	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,550	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)	357	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,145,882	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,145,882	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,145,882	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,384.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	494,245	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)	494,245	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1330 | Component CCN: 15-M330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	54,608	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	548,853	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)	1,510	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,510	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	547,343	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: 15-1330 Component CCN: 15-M330	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/26/2017 12:15 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	2,145,882	0.000000	0	0	90.00
91.00	Nursing School cost	0	2,145,882	0.000000	0	0	91.00
92.00	Allied health cost	0	2,145,882	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,145,882	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/26/2017 12:15 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,652	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,070	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)	3,726	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	265	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	317	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)	171	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)	380	15.00
16.00	Nursery days (title V or XIX only)	59	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	129.14	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)	5,849,796	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)	40,937	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)	329,474	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,520,322	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,520,322	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,088.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	186,188	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)	186,188	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/26/2017 12:15 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	501,353	380	1,319.35	59	77,842	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,526,592	398	3,835.66	4	15,343	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)	411,461	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	690,834	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)	24,614	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	18,387	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	43,001	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	647,833	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,344	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,088.82	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,463,374	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/26/2017 12:15 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	509,714	5,849,796	0.087134	1,463,374	127,510	90.00
91.00	Nursing School cost	0	5,849,796	0.000000	1,463,374	0	91.00
92.00	Allied health cost	0	5,849,796	0.000000	1,463,374	0	92.00
93.00	All other Medical Education	0	5,849,796	0.000000	1,463,374	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1330 Component CCN: 15-M330	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/26/2017 12:15 pm
	Title XIX	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,550	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,550	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,550	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)	106	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)	380	15.00
16.00	Nursery days (title V or XIX only)	59	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,145,882	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,145,882	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,145,882	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,384.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	146,751	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)	146,751	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1330 | Component CCN: 15-M330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/26/2017 12:15 pm

Title XIX | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	32,411	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	179,162	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)	14,207	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	868	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	15,075	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	164,087	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: 15-1330 Component CCN: 15-M330	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/26/2017 12:15 pm
	Title XIX	Subprovider - IPF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	207,750	2,145,882	0.096813	0	0	90.00
91.00	Nursing School cost	0	2,145,882	0.000000	0	0	91.00
92.00	Allied health cost	0	2,145,882	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,145,882	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,747,291		30.00
31.00	03100	INTENSIVE CARE UNIT		387,175		31.00
40.00	04000	SUBPROVIDER - IPF		4,941		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.546948	124,510	68,100	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.243629	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.183441	439,165	80,561	54.00
60.00	06000	LABORATORY	0.248422	1,137,477	282,574	60.00
65.00	06500	RESPIRATORY THERAPY	0.264080	1,247,039	329,318	65.00
66.00	06600	PHYSICAL THERAPY	0.445866	157,402	70,180	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.555657	112,247	62,371	67.00
68.00	06800	SPEECH PATHOLOGY	0.470615	58,908	27,723	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.740524	996,367	737,834	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285933	1,433,426	409,864	73.00
76.00	03020	OP PSYCH	0.961276	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.427827	361	154	90.00
90.01	09001	CLINIC - AMO	0.243234	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.850044	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.325870	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	8.234082	0	0	90.04
91.00	09100	EMERGENCY	1.210596	4,738	5,736	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.665645	28,134	18,727	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		5,739,774	2,093,142	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)		5,739,774		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1330 | Component CCN: 15-M330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		452,540		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.546948	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.243629	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.183441	14,026	2,573	54.00
60.00	06000	LABORATORY	0.248422	51,301	12,744	60.00
65.00	06500	RESPIRATORY THERAPY	0.264080	16,909	4,465	65.00
66.00	06600	PHYSICAL THERAPY	0.445866	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.555657	180	100	67.00
68.00	06800	SPEECH PATHOLOGY	0.470615	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.740524	6,197	4,589	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285933	105,398	30,137	73.00
76.00	03020	OP PSYCH	0.961276	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.427827	0	0	90.00
90.01	09001	CLINIC - AMO	0.243234	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.850044	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.325870	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	8.234082	0	0	90.04
91.00	09100	EMERGENCY	1.210596	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.665645	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		194,011	54,608	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)		194,011		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1330 | Component CCN: 15-Z330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.546948	2,920	1,597	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.243629	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.183441	11,947	2,192	54.00
60.00	06000	LABORATORY	0.248422	36,202	8,993	60.00
65.00	06500	RESPIRATORY THERAPY	0.264080	14,531	3,837	65.00
66.00	06600	PHYSICAL THERAPY	0.445866	75,095	33,482	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.555657	64,358	35,761	67.00
68.00	06800	SPEECH PATHOLOGY	0.470615	2,440	1,148	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.740524	29,573	21,900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285933	104,839	29,977	73.00
76.00	03020	OP PSYCH	0.961276	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.427827	0	0	90.00
90.01	09001	CLINIC - AMO	0.243234	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.850044	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.325870	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	8.234082	0	0	90.04
91.00	09100	EMERGENCY	1.210596	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.665645	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		341,905	138,887	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)		341,905		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/26/2017 12:15 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		333,374		30.00
31.00	03100	INTENSIVE CARE UNIT		39,240		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		38,783		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.546948	50,578	27,664	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.243629	30,643	68,752	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.183441	80,106	14,695	54.00
60.00	06000	LABORATORY	0.248422	254,468	63,215	60.00
65.00	06500	RESPIRATORY THERAPY	0.264080	109,399	28,890	65.00
66.00	06600	PHYSICAL THERAPY	0.445866	3,342	1,490	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.555657	1,797	999	67.00
68.00	06800	SPEECH PATHOLOGY	0.470615	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.740524	72,070	53,370	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285933	368,231	105,289	73.00
76.00	03020	OP PSYCH	0.961276	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.427827	0	0	90.00
90.01	09001	CLINIC - AMO	0.243234	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.850044	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.325870	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	8.234082	0	0	90.04
91.00	09100	EMERGENCY	1.210596	38,904	47,097	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.665645	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		1,009,538	411,461	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,009,538		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1330 | Component CCN: 15-M330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/26/2017 12:15 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		496,427		40.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.546948	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.243629	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.183441	948	174	54.00
60.00	06000	LABORATORY	0.248422	37,653	9,354	60.00
65.00	06500	RESPIRATORY THERAPY	0.264080	10,171	2,686	65.00
66.00	06600	PHYSICAL THERAPY	0.445866	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.555657	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.470615	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.740524	2,683	1,987	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285933	62,157	17,773	73.00
76.00	03020	OP PSYCH	0.961276	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.427827	0	0	90.00
90.01	09001	CLINIC - AMO	0.243234	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.850044	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.325870	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	8.234082	0	0	90.04
91.00	09100	EMERGENCY	1.210596	361	437	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.665645	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		113,973	32,411	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)		113,973		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1330 | Component CCN: 15-Z330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/26/2017 12:15 pm

Title XIX | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.546948	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.243629	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.183441	0	0	54.00
60.00	06000	LABORATORY	0.248422	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.264080	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.445866	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.555657	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.470615	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.740524	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.285933	0	0	73.00
76.00	03020	OP PSYCH	0.961276	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.427827	0	0	90.00
90.01	09001	CLINIC - AMO	0.243234	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.850044	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.325870	0	0	90.03
90.04	04950	INTENSIVE OP BEHAVIORAL HEALTH	8.234082	0	0	90.04
91.00	09100	EMERGENCY	1.210596	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.665645	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1330	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/26/2017 12:15 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,093,556	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,093,556	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	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)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	5,144,492	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)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	66,960	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,340,216	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)	2,737,316	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)	2,737,316	30.00
31.00	Primary payer payments	630	31.00
32.00	Subtotal (line 30 minus line 31)	2,736,686	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	227,966	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	148,178	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	227,966	36.00
37.00	Subtotal (see instructions)	2,884,864	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,884,864	40.00
40.01	Sequestration adjustment (see instructions)	57,697	40.01
41.00	Interim payments	2,637,690	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	189,477	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Hospital | Cost

		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		3,557,532		2,506,090	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	08/01/2016	253,300	08/01/2016	131,600	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)		253,300		131,600	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)		3,810,832		2,637,690	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		363,785		189,477	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,174,617		2,827,167	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: 15-1330 | Component CCN: 15-M330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		272,995		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		272,995		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		13,130		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		286,125		0	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: 15-1330 | Component CCN: 15-Z330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2017 12:15 pm

Title XVIII | Swing Beds - SNF | Cost

		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		465,656		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		465,656		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		49,234		0	6.02
7.00	Total Medicare program liability (see instructions)		416,422		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: 15-1330	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/26/2017 12:15 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1,597	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,794	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	668	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	4,124	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	92,352,687	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	178,551	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1330 Component CCN: 15-Z330	Period: From 01/01/2016 To 12/31/2016	Worksheet E-2 Date/Time Prepared: 5/26/2017 12:15 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	291,422	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	140,276	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	265	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	431,698	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	431,698	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	431,698	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	7,406	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	424,292	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	966	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	628	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	966	0	18.00
19.00	Total (see instructions)	424,920	0	19.00
19.01	Sequestration adjustment (see instructions)	8,498	0	19.01
20.00	Interim payments	465,656	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-49,234	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1330 | Component CCN: 15-Z330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-2 | Date/Time Prepared: 5/26/2017 12:15 pm

Title XIX | Swing Beds - SNF | PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1330	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part V Date/Time Prepared: 5/26/2017 12:15 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,595,853	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	4,595,853	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,641,812	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	4,641,812	19.00
20.00	Deductibles (exclude professional component)	417,256	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,224,556	22.00
23.00	Coinsurance	8,050	23.00
24.00	Subtotal (line 22 minus line 23)	4,216,506	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	66,626	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	43,307	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	66,626	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,259,813	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	4,259,813	30.00
30.01	Sequestration adjustment (see instructions)	85,196	30.01
31.00	Interim payments	3,810,832	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	363,785	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1330 Component CCN: 15-M330	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part II Date/Time Prepared: 5/26/2017 12:15 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	317,231	1.00
2.00	Net IPF PPS Outlier Payments	6,418	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	4.234973	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	323,649	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	323,649	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	323,649	18.00
19.00	Deductibles	45,080	19.00
20.00	Subtotal (line 18 minus line 19)	278,569	20.00
21.00	Coinsurance	0	21.00
22.00	Subtotal (line 20 minus line 21)	278,569	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	20,608	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	13,395	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	20,608	25.00
26.00	Subtotal (sum of lines 22 and 24)	291,964	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	291,964	31.00
31.01	Sequestration adjustment (see instructions)	5,839	31.01
32.00	Interim payments	272,995	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	13,130	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	6,418	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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 5/26/2017 12:15 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	536,428	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	21,043,860	0	0	0	4.00
5.00	Other receivable	-7,938,760	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,588,768	0	0	0	6.00
7.00	Inventory	638,401	0	0	0	7.00
8.00	Prepaid expenses	191,457	0	0	0	8.00
9.00	Other current assets	94,263	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)	4,976,881	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	367,244	0	0	0	12.00
13.00	Land improvements	1,613,861	0	0	0	13.00
14.00	Accumulated depreciation	-1,407,079	0	0	0	14.00
15.00	Buildings	40,366,746	0	0	0	15.00
16.00	Accumulated depreciation	-17,080,163	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	4,614,940	0	0	0	19.00
20.00	Accumulated depreciation	-2,639,266	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	24,244,457	0	0	0	23.00
24.00	Accumulated depreciation	-19,576,555	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	30,504,185	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	7,069,363	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,069,363	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	42,550,429	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,237,370	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,859,450	0	0	0	38.00
39.00	Payroll taxes payable	282,120	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				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,164,412	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,543,352	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	31,177,428	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	211,271	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	31,388,699	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	37,932,051	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	4,618,378				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	4,618,378	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	42,550,429	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 5/26/2017 12:15 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		6,949,867		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,269,647				2.00
3.00	Total (sum of line 1 and line 2)		4,680,220		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		4,680,220		0		11.00
12.00	CHANGE IN PY FUND BALANCE	61,842		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		61,842		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		4,618,378		0		19.00

		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (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	CHANGE IN PY FUND BALANCE		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: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/26/2017 12:15 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,612,655		5,612,655	1.00
2.00	SUBPROVIDER - IPF	2,077,227		2,077,227	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	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)	7,689,882		7,689,882	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	831,615		831,615	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)	831,615		831,615	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,521,497		8,521,497	17.00
18.00	Ancillary services	11,084,592	50,985,390	62,069,982	18.00
19.00	Outpatient services	296,707	14,877,241	15,173,948	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		0	0	22.00
23.00	AMBULANCE SERVICES	0	2,611,322	2,611,322	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	TRANSPORTATION REVENUE	0	9,184	9,184	27.00
27.01	RX REVENUE	3,912,680	4,403,419	8,316,099	27.01
27.02	OTHER	57	3,138,744	3,138,801	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	23,815,533	76,025,300	99,840,833	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		53,216,580		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		53,216,580		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1330 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-3 | Date/Time Prepared: 5/26/2017 12:15 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	99,840,833	1.00
2.00	Less contractual allowances and discounts on patients' accounts	52,851,166	2.00
3.00	Net patient revenues (line 1 minus line 2)	46,989,667	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	53,216,580	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-6,226,913	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	572,251	6.00
7.00	Income from investments	219,797	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	448,232	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	606,060	17.00
18.00	Revenue from sale of medical records and abstracts	25,363	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	280,246	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC	213,882	24.00
24.01	CEDIT INCOME	1,348,152	24.01
24.02	FITNESS REVENUE	103,804	24.02
24.03	MANAGEMENT REVENUE	139,479	24.03
25.00	Total other income (sum of lines 6-24)	3,957,266	25.00
26.00	Total (line 5 plus line 25)	-2,269,647	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,269,647	29.00