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: 15-1317	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/30/2017 10:32 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/30/2017 Time: 10:32 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GREENE COUNTY GENERAL HOSPITAL (15-1317) 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	154,191	-631,522	0	265,256	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	61,314	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	215,505	-631,522	0	265,256	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2017 10:26 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: R.R 1	PO Box: 1000			1.00
2.00	City: LINTON	State: IN	Zip Code: 47441-9457	County: GREENE	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	GREENE COUNTY GENERAL HOSPITAL	151317	99915	1	02/01/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	GREENE COUNTY GENERAL HOSPITAL	15Z317	99915		02/01/2003	N	O	N	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.	0		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: 15-1317	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 10:26 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			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)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1317	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 10:26 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 10:26 am

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

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

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

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

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

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		V	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.	Y		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:	94,937	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.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 10:26 am

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N	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: 15-1317	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 10:26 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2016	12/31/2016	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: 15-1317	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 10:26 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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	03/10/2017	Y	03/10/2017	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: 15-1317	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 10:26 am

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

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

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		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.	N		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.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	STEVE	DERYKE	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-383-4282	SDERYKE@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1317	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 10:26 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR CONSULTANT		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: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2017 10:26 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	20	7,320	50,664.00	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)		20	7,320	50,664.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,830	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,150	50,664.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				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: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2017 10:26 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,185	54	1,747			1.00
2.00	HMO and other (see instructions)	58	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	349	0	349			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,534	54	2,096			7.00
8.00	INTENSIVE CARE UNIT	270	5	364			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		96	153			13.00
14.00	Total (see instructions)	1,804	155	2,613	0.00	195.38	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	195.38	27.00
28.00	Observation Bed Days		170	1,052			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	40	40			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: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2017 10:26 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	469	62	716	1.00
2.00	HMO and other (see instructions)			13	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	469	62	716	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	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: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 5/30/2017 10:26 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.325877	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,215,763	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?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,805,990	5.00
6.00	Medicaid charges	16,304,108	6.00
7.00	Medicaid cost (line 1 times line 6)	5,313,134	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,291,381	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	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)	1,291,381	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)	438,479	0	438,479	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	142,890	0	142,890	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)	142,890	0	142,890	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	5,005,581	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	644,772	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	4,360,809	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,421,087	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,563,977	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,855,358	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/30/2017 10:26 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		951,403	951,403	42,202	993,605	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		499,766	499,766	2,345	502,111	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,957,897	2,957,897	-451,990	2,505,907	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,558,095	2,440,453	3,998,548	-124,683	3,873,865	5.00
7.00	00700	OPERATION OF PLANT	448,912	1,015,449	1,464,361	0	1,464,361	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	281,631	281,631	0	281,631	8.00
9.00	00900	HOUSEKEEPING	362,367	110,109	472,476	0	472,476	9.00
10.00	01000	DIETARY	514,109	512,537	1,026,646	-909,501	117,145	10.00
11.00	01100	CAFETERIA	0	0	0	909,501	909,501	11.00
13.00	01300	NURSING ADMINISTRATION	686,986	122,133	809,119	0	809,119	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	37,418	37,418	0	37,418	14.00
15.00	01500	PHARMACY	453,970	23,016	476,986	0	476,986	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	219,509	25,891	245,400	0	245,400	16.00
17.00	01700	SOCIAL SERVICE	161,221	123	161,344	0	161,344	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	462,474	462,474	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,317,538	483,808	2,801,346	21,157	2,822,503	30.00
31.00	03100	INTENSIVE CARE UNIT	721,791	50,944	772,735	0	772,735	31.00
43.00	04300	NURSERY	309	0	309	0	309	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	398,786	618,367	1,017,153	-462,474	554,679	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	74,650	74,650	-21,157	53,493	52.00
53.00	05300	ANESTHESIOLOGY	0	2,826	2,826	0	2,826	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	820,703	529,835	1,350,538	0	1,350,538	54.00
60.00	06000	LABORATORY	794,908	1,263,110	2,058,018	0	2,058,018	60.00
65.00	06500	RESPIRATORY THERAPY	423,348	38,402	461,750	0	461,750	65.00
66.00	06600	PHYSICAL THERAPY	267,306	26,435	293,741	0	293,741	66.00
67.00	06700	OCCUPATIONAL THERAPY	149,970	0	149,970	0	149,970	67.00
68.00	06800	SPEECH PATHOLOGY	16,626	0	16,626	0	16,626	68.00
69.00	06900	ELECTROCARDIOLOGY	0	16,349	16,349	0	16,349	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	566,677	566,677	-32	566,645	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	32	32	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	222,957	1,298,947	1,521,904	0	1,521,904	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	999,404	603,172	1,602,576	0	1,602,576	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,538,815	14,551,348	26,090,163	-532,126	25,558,037	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	243,991	-1,357	242,634	0	242,634	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	532,126	532,126	194.00
200.00		TOTAL (SUM OF LINES 118-199)	11,782,806	14,549,991	26,332,797	0	26,332,797	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/30/2017 10:26 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	-33,142	960,463	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-211,882	290,229	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	532,126	3,038,033	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-655,459	3,218,406	5.00
7.00	00700	OPERATION OF PLANT	0	1,464,361	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	281,631	8.00
9.00	00900	HOUSEKEEPING	0	472,476	9.00
10.00	01000	DIETARY	0	117,145	10.00
11.00	01100	CAFETERIA	-336,002	573,499	11.00
13.00	01300	NURSING ADMINISTRATION	0	809,119	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	37,418	14.00
15.00	01500	PHARMACY	0	476,986	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,186	240,214	16.00
17.00	01700	SOCIAL SERVICE	0	161,344	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-222,833	239,641	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-419,723	2,402,780	30.00
31.00	03100	INTENSIVE CARE UNIT	0	772,735	31.00
43.00	04300	NURSERY	0	309	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	554,679	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	53,493	52.00
53.00	05300	ANESTHESIOLOGY	0	2,826	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,350,538	54.00
60.00	06000	LABORATORY	-23,505	2,034,513	60.00
65.00	06500	RESPIRATORY THERAPY	0	461,750	65.00
66.00	06600	PHYSICAL THERAPY	-918	292,823	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	149,970	67.00
68.00	06800	SPEECH PATHOLOGY	0	16,626	68.00
69.00	06900	ELECTROCARDIOLOGY	0	16,349	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	566,645	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	32	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,521,904	73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	1,602,576	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,376,524	24,181,513	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	242,634	192.00
194.00	07950	FOUNDATION / MOBS	0	532,126	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-1,376,524	24,956,273	200.00

RECLASSIFICATIONS | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/30/2017 10:26 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CRNA RECLASS				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	462,474	1.00
	0		0	462,474	
	B - LABOR & DELIVERY				
1.00	DELIVERY ROOM & LABOR ROOM	52.00	25,543	0	1.00
	0		25,543	0	
	C - DIETARY RECLASS				
1.00	CAFETERIA	11.00	455,447	454,054	1.00
	0		455,447	454,054	
	E - INSURANCE RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	42,202	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,345	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	80,136	3.00
	0		0	124,683	
	F - OB RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	0	46,700	1.00
	TOTALS		0	46,700	
	G - IMPLANTABLE DEVICE RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	32	1.00
	TOTALS		0	32	
	H - RELATED PARTIES RECLASS				
1.00	FOUNDATION / MOBS	194.00	0	532,126	1.00
	0		0	532,126	
500.00	Grand Total: Increases		480,990	1,620,069	500.00

RECLASSIFICATIONS | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/30/2017 10:26 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CRNA RECLASS					
1.00	OPERATING ROOM	50.00	0	462,474	0	1.00
	0		0	462,474		
	B - LABOR & DELIVERY					
1.00	ADULTS & PEDIATRICS	30.00	25,543	0	0	1.00
	0		25,543	0		
	C - DIETARY RECLASS					
1.00	DIETARY	10.00	455,447	454,054	0	1.00
	0		455,447	454,054		
	E - INSURANCE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	124,683	12	1.00
2.00		0.00	0	0	12	2.00
3.00		0.00	0	0	0	3.00
	0		0	124,683		
	F - OB RECLASS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	0	46,700	0	1.00
	TOTALS		0	46,700		
	G - IMPLANTABLE DEVICE RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	32	0	1.00
	TOTALS		0	32		
	H - RELATED PARTIES RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	532,126	0	1.00
	0		0	532,126		
500.00	Grand Total: Decreases		480,990	1,620,069		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2017 10:26 am

			Acquisitions				
		Beginning Balances	Purchases	Donation	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	651,198	0	0	0	0	1.00
2.00	Land Improvements	335,729	0	0	0	0	2.00
3.00	Buildings and Fixtures	7,306,858	0	0	0	189,488	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,772,581	68,349	0	68,349	205,366	5.00
6.00	Movable Equipment	2,344,405	293,798	0	293,798	303,769	6.00
7.00	HIT designated Assets	1,062,388	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,473,159	362,147	0	362,147	698,623	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	14,473,159	362,147	0	362,147	698,623	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	651,198	0	1.00
2.00	Land Improvements	335,729	0	2.00
3.00	Buildings and Fixtures	7,117,370	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	2,635,564	0	5.00
6.00	Movable Equipment	2,334,434	0	6.00
7.00	HIT designated Assets	1,062,388	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,136,683	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	14,136,683	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 15-1317	Period: From 01/01/2016 To 12/31/2016	Worksheet A-7 Part II Date/Time Prepared: 5/30/2017 10:26 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	564,857	0	344,344	42,202	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	497,421	0	0	2,345	0	2.00
3.00	Total (sum of lines 1-2)	1,062,278	0	344,344	44,547	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	CAP REL COSTS-BLDG & FIXT	0	951,403	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	499,766	2.00
3.00	Total (sum of lines 1-2)	0	1,451,169	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 5/30/2017 10:26 am

	Cost Center Description	COMPUTATION OF RATIOS Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	11,802,249	0	11,802,249	0.834867	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,334,434	0	2,334,434	0.165133	0	2.00
3.00	Total (sum of lines 1-2)	14,136,683	0	14,136,683	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	531,715	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	285,539	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	817,254	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	344,344	84,404	0	0	960,463	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,690	0	0	290,229	2.00
3.00	Total (sum of lines 1-2)	344,344	89,094	0	0	1,250,692	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/30/2017 10:26 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-1,006	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-5,823	ADULTS & PEDIATRICS	30.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-4,417	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-390,705			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-336,002	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		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-5,186	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 - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/30/2017 10:26 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-211,882	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	CPR TRAINING	B	-331	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MISC REVENUE - ADMIN	B	-22,943	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	AHA DUES	A	-1,992	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	IHA DUES	A	-608	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MARKETING & ADVERTISING	A	-69,077	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	RENTAL OF PROVIDER SPACE - BENEFITS	B	-56,465	CAP REL COSTS-BLDG & FIXT	1.00	9	33.05
33.06	GIFT CARD USAGE	B	-4,527	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	THERAPY REVENUE	B	-918	PHYSICAL THERAPY	66.00	0	33.07
33.08	CRNA TO MARKET ADJUSTMENT	A	-222,833	NONPHYSICIAN ANESTHETISTS	19.00	0	33.08
33.09	BOND INTEREST	A	177	CAP REL COSTS-BLDG & FIXT	1.00	9	33.09
33.10	DR RIDGE OFFSET	A	-46,700	ADULTS & PEDIATRICS	30.00	0	33.10
33.11	LLC AND HHC BENEFITS	A	532,126	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	HOSPITAL ASSESSMENT FEE	A	-550,558	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	BOND AMORTIZATION EXPENSE ADJUSTMENT	A	23,146	CAP REL COSTS-BLDG & FIXT	1.00	9	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,376,524				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2017 10:26 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	23,505	23,505	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	367,200	367,200	0	0	0	2.00
3.00	91.00	EMERGENCY	626,672	0	626,672	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,017,377	390,705	626,672		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	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	60.00	LABORATORY	0	0	0	23,505	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	367,200	2.00
3.00	91.00	EMERGENCY	0	0	0	0	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	390,705	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/30/2017 10:26 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	960,463	960,463				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	290,229		290,229			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,038,033	0	0	3,038,033		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,218,406	84,961	25,673	401,733	3,730,773	5.00
7.00	00700	OPERATION OF PLANT	1,464,361	127,593	38,556	115,746	1,746,256	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	281,631	6,593	1,992	0	290,216	8.00
9.00	00900	HOUSEKEEPING	472,476	7,295	2,204	93,431	575,406	9.00
10.00	01000	DIETARY	117,145	34,437	10,406	15,125	177,113	10.00
11.00	01100	CAFETERIA	573,499	37,826	11,430	117,431	740,186	11.00
13.00	01300	NURSING ADMINISTRATION	809,119	4,740	1,432	177,130	992,421	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	37,418	42,527	12,851	0	92,796	14.00
15.00	01500	PHARMACY	476,986	21,184	6,401	117,050	621,621	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	240,214	14,114	4,265	56,597	315,190	16.00
17.00	01700	SOCIAL SERVICE	161,344	3,787	1,144	41,569	207,844	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	239,641	0	0	0	239,641	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,402,780	162,110	48,987	590,959	3,204,836	30.00
31.00	03100	INTENSIVE CARE UNIT	772,735	35,483	10,722	186,104	1,005,044	31.00
43.00	04300	NURSERY	309	6,752	2,040	80	9,181	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	554,679	103,351	31,230	102,821	792,081	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	53,493	44,274	13,379	6,586	117,732	52.00
53.00	05300	ANESTHESIOLOGY	2,826	0	0	0	2,826	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,350,538	60,295	18,220	211,607	1,640,660	54.00
60.00	06000	LABORATORY	2,034,513	24,692	7,461	204,956	2,271,622	60.00
65.00	06500	RESPIRATORY THERAPY	461,750	6,779	2,048	109,154	579,731	65.00
66.00	06600	PHYSICAL THERAPY	292,823	12,604	3,809	68,921	378,157	66.00
67.00	06700	OCCUPATIONAL THERAPY	149,970	12,604	3,809	38,668	205,051	67.00
68.00	06800	SPEECH PATHOLOGY	16,626	3,773	1,140	4,287	25,826	68.00
69.00	06900	ELECTROCARDIOLOGY	16,349	2,105	636	0	19,090	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	566,645	0	0	0	566,645	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32	0	0	0	32	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,521,904	10,645	3,217	57,486	1,593,252	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,602,576	75,176	22,716	257,682	1,958,150	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,181,513	945,700	285,768	2,975,123	24,099,379	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,681	1,112	0	4,793	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	242,634	11,082	3,349	62,910	319,975	192.00
194.00	07950	FOUNDATION / MOBS	532,126	0	0	0	532,126	194.00
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)	24,956,273	960,463	290,229	3,038,033	24,956,273	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/30/2017 10:26 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,730,773					5.00
7.00	00700	OPERATION OF PLANT	306,936	2,053,192				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	51,011	18,101	359,328			8.00
9.00	00900	HOUSEKEEPING	101,138	20,027	0	696,571		9.00
10.00	01000	DIETARY	31,131	94,538	0	297	303,079	10.00
11.00	01100	CAFETERIA	130,101	103,843	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	174,436	13,012	1,838	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,311	116,746	0	8,312	0	14.00
15.00	01500	PHARMACY	109,261	58,155	0	9,945	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	55,400	38,746	0	1,336	0	16.00
17.00	01700	SOCIAL SERVICE	36,532	10,395	0	148	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	42,121	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	563,317	445,028	96,419	266,530	251,972	30.00
31.00	03100	INTENSIVE CARE UNIT	176,655	97,409	33,209	59,819	51,107	31.00
43.00	04300	NURSERY	1,614	18,537	0	4,453	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	139,222	283,723	25,490	72,673	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,694	121,544	241	7,273	0	52.00
53.00	05300	ANESTHESIOLOGY	497	0	0	1,187	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	288,376	165,523	44,287	36,366	0	54.00
60.00	06000	LABORATORY	399,278	67,787	0	31,171	0	60.00
65.00	06500	RESPIRATORY THERAPY	101,898	18,610	2,915	11,370	0	65.00
66.00	06600	PHYSICAL THERAPY	66,468	34,602	38,520	32,952	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	36,041	34,602	11,851	445	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,539	10,359	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,355	5,779	0	297	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	99,598	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	280,043	29,223	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	344,180	206,377	90,539	122,458	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,580,159	2,012,666	345,309	667,032	303,079	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	842	10,104	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	56,241	30,422	14,019	26,273	0	192.00
194.00	07950	FOUNDATION / MOBS	93,531	0	0	3,266	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,730,773	2,053,192	359,328	696,571	303,079	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/30/2017 10:26 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	974,130					11.00
13.00	01300	NURSING ADMINISTRATION	55,619	1,237,326				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	234,165			14.00
15.00	01500	PHARMACY	45,054	0	0	844,036		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	46,639	0	0	0	457,311	16.00
17.00	01700	SOCIAL SERVICE	7,320	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	261,342	572,693	0	0	44,418	30.00
31.00	03100	INTENSIVE CARE UNIT	66,109	141,047	0	0	5,703	31.00
43.00	04300	NURSERY	0	0	0	0	1,037	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	44,903	357,986	0	0	23,159	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,019	0	0	0	691	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	89,580	0	0	0	10,543	54.00
60.00	06000	LABORATORY	126,106	0	0	0	23,678	60.00
65.00	06500	RESPIRATORY THERAPY	44,601	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	27,696	0	0	0	19,530	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,735	0	0	0	173	67.00
68.00	06800	SPEECH PATHOLOGY	453	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	1,210	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	234,165	0	2,074	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,999	0	0	844,036	2,765	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	115,163	165,600	0	0	322,330	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	967,338	1,237,326	234,165	844,036	457,311	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,792	0	0	0	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
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)	974,130	1,237,326	234,165	844,036	457,311	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/30/2017 10:26 am

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	262,239					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	281,762				19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	177,592	0	5,884,147	0	5,884,147	30.00
31.00	03100	INTENSIVE CARE UNIT	66,390	0	1,702,492	0	1,702,492	31.00
43.00	04300	NURSERY	0	0	34,822	0	34,822	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	1,739,237	0	1,739,237	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	271,194	0	271,194	52.00
53.00	05300	ANESTHESIOLOGY	0	281,762	286,272	0	286,272	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,275,335	0	2,275,335	54.00
60.00	06000	LABORATORY	0	0	2,919,642	0	2,919,642	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	759,125	0	759,125	65.00
66.00	06600	PHYSICAL THERAPY	0	0	597,925	0	597,925	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	301,898	0	301,898	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	41,177	0	41,177	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	29,731	0	29,731	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	902,482	0	902,482	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	38	0	38	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,769,318	0	2,769,318	73.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	18,257	0	3,343,054	0	3,343,054	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	262,239	281,762	23,857,889	0	23,857,889	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	15,739	0	15,739	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	453,722	0	453,722	192.00
194.00	07950	FOUNDATION / MOBS	0	0	628,923	0	628,923	194.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	262,239	281,762	24,956,273	0	24,956,273	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/30/2017 10:26 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	84,961	25,673	110,634	0	5.00
7.00	00700	OPERATION OF PLANT	0	127,593	38,556	166,149	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,593	1,992	8,585	0	8.00
9.00	00900	HOUSEKEEPING	0	7,295	2,204	9,499	0	9.00
10.00	01000	DIETARY	0	34,437	10,406	44,843	0	10.00
11.00	01100	CAFETERIA	0	37,826	11,430	49,256	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,740	1,432	6,172	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	42,527	12,851	55,378	0	14.00
15.00	01500	PHARMACY	0	21,184	6,401	27,585	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,114	4,265	18,379	0	16.00
17.00	01700	SOCIAL SERVICE	0	3,787	1,144	4,931	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	162,110	48,987	211,097	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	35,483	10,722	46,205	0	31.00
43.00	04300	NURSERY	0	6,752	2,040	8,792	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	103,351	31,230	134,581	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	44,274	13,379	57,653	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	60,295	18,220	78,515	0	54.00
60.00	06000	LABORATORY	0	24,692	7,461	32,153	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,779	2,048	8,827	0	65.00
66.00	06600	PHYSICAL THERAPY	0	12,604	3,809	16,413	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,604	3,809	16,413	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,773	1,140	4,913	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,105	636	2,741	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 PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,645	3,217	13,862	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	75,176	22,716	97,892	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	945,700	285,768	1,231,468	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,681	1,112	4,793	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,082	3,349	14,431	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
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	960,463	290,229	1,250,692	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/30/2017 10:26 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	110,634					5.00
7.00	00700	OPERATION OF PLANT	9,101	175,250				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,513	1,545	11,643			8.00
9.00	00900	HOUSEKEEPING	2,999	1,709	0	14,207		9.00
10.00	01000	DIETARY	923	8,069	0	6	53,841	10.00
11.00	01100	CAFETERIA	3,858	8,863	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	5,172	1,111	60	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	484	9,965	0	170	0	14.00
15.00	01500	PHARMACY	3,240	4,964	0	203	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,643	3,307	0	27	0	16.00
17.00	01700	SOCIAL SERVICE	1,083	887	0	3	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,249	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	16,710	37,990	3,124	5,435	44,762	30.00
31.00	03100	INTENSIVE CARE UNIT	5,238	8,314	1,076	1,220	9,079	31.00
43.00	04300	NURSERY	48	1,582	0	91	0	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,128	24,217	826	1,482	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	614	10,374	8	148	0	52.00
53.00	05300	ANESTHESIOLOGY	15	0	0	24	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,551	14,128	1,435	742	0	54.00
60.00	06000	LABORATORY	11,840	5,786	0	636	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,022	1,588	94	232	0	65.00
66.00	06600	PHYSICAL THERAPY	1,971	2,953	1,248	672	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,069	2,953	384	9	0	67.00
68.00	06800	SPEECH PATHOLOGY	135	884	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	99	493	0	6	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,953	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,304	2,494	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	10,206	17,615	2,934	2,498	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	106,168	171,791	11,189	13,604	53,841	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25	862	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,668	2,597	454	536	0	192.00
194.00	07950	FOUNDATION / MOBS	2,773	0	0	67	0	194.00
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)	110,634	175,250	11,643	14,207	53,841	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/30/2017 10:26 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	61,977					11.00
13.00	01300	NURSING ADMINISTRATION	3,539	16,054				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	65,997			14.00
15.00	01500	PHARMACY	2,866	0	0	38,858		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,967	0	0	0	26,323	16.00
17.00	01700	SOCIAL SERVICE	466	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,628	7,430	0	0	2,557	30.00
31.00	03100	INTENSIVE CARE UNIT	4,206	1,830	0	0	328	31.00
43.00	04300	NURSERY	0	0	0	0	60	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,857	4,645	0	0	1,333	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	192	0	0	0	40	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,699	0	0	0	607	54.00
60.00	06000	LABORATORY	8,023	0	0	0	1,363	60.00
65.00	06500	RESPIRATORY THERAPY	2,838	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,762	0	0	0	1,124	66.00
67.00	06700	OCCUPATIONAL THERAPY	874	0	0	0	10	67.00
68.00	06800	SPEECH PATHOLOGY	29	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	70	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	65,997	0	119	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,272	0	0	38,858	159	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,327	2,149	0	0	18,553	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	61,545	16,054	65,997	38,858	26,323	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	432	0	0	0	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
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)	61,977	16,054	65,997	38,858	26,323	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/30/2017 10:26 am

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	7,370					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	1,249				19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,991		350,724	0	350,724	30.00
31.00	03100	INTENSIVE CARE UNIT	1,866		79,362	0	79,362	31.00
43.00	04300	NURSERY	0		10,573	0	10,573	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0		174,069	0	174,069	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		69,029	0	69,029	52.00
53.00	05300	ANESTHESIOLOGY	0		39	0	39	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		109,677	0	109,677	54.00
60.00	06000	LABORATORY	0		59,801	0	59,801	60.00
65.00	06500	RESPIRATORY THERAPY	0		16,601	0	16,601	65.00
66.00	06600	PHYSICAL THERAPY	0		26,143	0	26,143	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		21,712	0	21,712	67.00
68.00	06800	SPEECH PATHOLOGY	0		5,961	0	5,961	68.00
69.00	06900	ELECTROCARDIOLOGY	0		3,409	0	3,409	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		69,069	0	69,069	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		64,949	0	64,949	73.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	513		159,687	0	159,687	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,370	0	1,220,805	0	1,220,805	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		5,680	0	5,680	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		20,118	0	20,118	192.00
194.00	07950	FOUNDATION / MOBS	0		2,840	0	2,840	194.00
200.00		Cross Foot Adjustments		1,249	1,249	0	1,249	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	7,370	1,249	1,250,692	0	1,250,692	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/30/2017 10:26 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	72,543					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		72,543				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	11,782,806			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,417	6,417	1,558,095	-3,730,773	21,225,500	5.00
7.00	00700	OPERATION OF PLANT	9,637	9,637	448,912	0	1,746,256	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	498	498	0	0	290,216	8.00
9.00	00900	HOUSEKEEPING	551	551	362,367	0	575,406	9.00
10.00	01000	DIETARY	2,601	2,601	58,662	0	177,113	10.00
11.00	01100	CAFETERIA	2,857	2,857	455,447	0	740,186	11.00
13.00	01300	NURSING ADMINISTRATION	358	358	686,986	0	992,421	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,212	3,212	0	0	92,796	14.00
15.00	01500	PHARMACY	1,600	1,600	453,970	0	621,621	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,066	1,066	219,509	0	315,190	16.00
17.00	01700	SOCIAL SERVICE	286	286	161,221	0	207,844	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	239,641	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,244	12,244	2,291,995	0	3,204,836	30.00
31.00	03100	INTENSIVE CARE UNIT	2,680	2,680	721,791	0	1,005,044	31.00
43.00	04300	NURSERY	510	510	309	0	9,181	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,806	7,806	398,786	0	792,081	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,344	3,344	25,543	0	117,732	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	2,826	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,554	4,554	820,703	0	1,640,660	54.00
60.00	06000	LABORATORY	1,865	1,865	794,908	0	2,271,622	60.00
65.00	06500	RESPIRATORY THERAPY	512	512	423,348	0	579,731	65.00
66.00	06600	PHYSICAL THERAPY	952	952	267,306	0	378,157	66.00
67.00	06700	OCCUPATIONAL THERAPY	952	952	149,970	0	205,051	67.00
68.00	06800	SPEECH PATHOLOGY	285	285	16,626	0	25,826	68.00
69.00	06900	ELECTROCARDIOLOGY	159	159	0	0	19,090	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	566,645	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	32	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	804	804	222,957	0	1,593,252	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,678	5,678	999,404	0	1,958,150	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	71,428	71,428	11,538,815	-3,730,773	20,368,606	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	278	278	0	0	4,793	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	837	837	243,991	0	319,975	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	532,126	194.00
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)	960,463	290,229	3,038,033		3,730,773	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.239913	4.000786	0.257836		0.175768	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		110,634	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.005212	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/30/2017 10:26 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PIECES OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	56,489					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	498	28,349				8.00
9.00	00900	HOUSEKEEPING	551	0	23,464			9.00
10.00	01000	DIETARY	2,601	0	10	6,636		10.00
11.00	01100	CAFETERIA	2,857	0	0	0	12,908	11.00
13.00	01300	NURSING ADMINISTRATION	358	145	0	0	737	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,212	0	280	0	0	14.00
15.00	01500	PHARMACY	1,600	0	335	0	597	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,066	0	45	0	618	16.00
17.00	01700	SOCIAL SERVICE	286	0	5	0	97	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,244	7,607	8,978	5,517	3,463	30.00
31.00	03100	INTENSIVE CARE UNIT	2,680	2,620	2,015	1,119	876	31.00
43.00	04300	NURSERY	510	0	150	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,806	2,011	2,448	0	595	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,344	19	245	0	40	52.00
53.00	05300	ANESTHESIOLOGY	0	0	40	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,554	3,494	1,225	0	1,187	54.00
60.00	06000	LABORATORY	1,865	0	1,050	0	1,671	60.00
65.00	06500	RESPIRATORY THERAPY	512	230	383	0	591	65.00
66.00	06600	PHYSICAL THERAPY	952	3,039	1,110	0	367	66.00
67.00	06700	OCCUPATIONAL THERAPY	952	935	15	0	182	67.00
68.00	06800	SPEECH PATHOLOGY	285	0	0	0	6	68.00
69.00	06900	ELECTROCARDIOLOGY	159	0	10	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 PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	804	0	0	0	265	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,678	7,143	4,125	0	1,526	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	55,374	27,243	22,469	6,636	12,818	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	278	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	837	1,106	885	0	90	192.00
194.00	07950	FOUNDATION / MOBS	0	0	110	0	0	194.00
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)	2,053,192	359,328	696,571	303,079	974,130	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	36.346758	12.675156	29.686797	45.671941	75.467152	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	175,250	11,643	14,207	53,841	61,977	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.102374	0.410702	0.605481	8.113472	4.801441	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/30/2017 10:26 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	11,641					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	566,667				14.00
15.00	01500	PHARMACY	0	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	66,150		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	158	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,388	0	0	6,425	107	30.00
31.00	03100	INTENSIVE CARE UNIT	1,327	0	0	825	40	31.00
43.00	04300	NURSERY	0	0	0	150	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,368	0	0	3,350	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	100	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,525	0	54.00
60.00	06000	LABORATORY	0	0	0	3,425	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,825	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	25	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	175	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	566,667	0	300	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	400	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,558	0	0	46,625	11	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,641	566,667	100	66,150	158	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
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)	1,237,326	234,165	844,036	457,311	262,239	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	106.290353	0.413232	8,440.360000	6.913243	1,659.740506	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	16,054	65,997	38,858	26,323	7,370	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.379091	0.116465	388.580000	0.397929	46.645570	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/30/2017 10:26 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			19.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	FOUNDATION / MOBS	0	194.00
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)	281,762	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2,817.620000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,249	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	12.490000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 10:26 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,884,147		5,884,147	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,702,492		1,702,492	0	0	31.00
43.00	04300	NURSERY	34,822		34,822	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,739,237		1,739,237	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	271,194		271,194	0	0	52.00
53.00	05300	ANESTHESIOLOGY	286,272		286,272	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,275,335		2,275,335	0	0	54.00
60.00	06000	LABORATORY	2,919,642		2,919,642	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	759,125	0	759,125	0	0	65.00
66.00	06600	PHYSICAL THERAPY	597,925	0	597,925	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	301,898	0	301,898	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	41,177	0	41,177	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	29,731		29,731	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	902,482		902,482	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38		38	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,769,318		2,769,318	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,343,054		3,343,054	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,966,367		1,966,367		0	92.00
200.00		Subtotal (see instructions)	25,824,256	0	25,824,256	0	0	200.00
201.00		Less Observation Beds	1,966,367		1,966,367		0	201.00
202.00		Total (see instructions)	23,857,889	0	23,857,889	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 10:26 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	2,627,607		2,627,607			30.00
31.00	03100	INTENSIVE CARE UNIT	893,266		893,266			31.00
43.00	04300	NURSERY	202,972		202,972			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	510,271	2,440,176	2,950,447	0.589483	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	91,124	2,939	94,063	2.883110	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	245,682	733,563	979,245	0.292340	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	613,496	14,717,595	15,331,091	0.148413	0.000000	54.00
60.00	06000	LABORATORY	1,118,969	13,471,176	14,590,145	0.200111	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	827,114	782,422	1,609,536	0.471642	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	145,941	2,047,765	2,193,706	0.272564	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	89,449	870,048	959,497	0.314642	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	7,924	110,744	118,668	0.346993	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	269,455	1,884,749	2,154,204	0.013801	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	882,569	1,154,442	2,037,011	0.443042	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	531	531	0.071563	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,813,445	7,712,095	9,525,540	0.290726	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	472,038	14,822,758	15,294,796	0.218575	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,648,999	1,648,999	1.192461	0.000000	92.00
200.00		Subtotal (see instructions)	10,811,322	62,400,002	73,211,324			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,811,322	62,400,002	73,211,324			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1317	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/30/2017 10:26 am
	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
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
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: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I | Date/Time Prepared: 5/30/2017 10:26 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,884,147		5,884,147	0	5,884,147	30.00
31.00	03100	INTENSIVE CARE UNIT	1,702,492		1,702,492	0	1,702,492	31.00
43.00	04300	NURSERY	34,822		34,822	0	34,822	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,739,237		1,739,237	0	1,739,237	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	271,194		271,194	0	271,194	52.00
53.00	05300	ANESTHESIOLOGY	286,272		286,272	0	286,272	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,275,335		2,275,335	0	2,275,335	54.00
60.00	06000	LABORATORY	2,919,642		2,919,642	0	2,919,642	60.00
65.00	06500	RESPIRATORY THERAPY	759,125	0	759,125	0	759,125	65.00
66.00	06600	PHYSICAL THERAPY	597,925	0	597,925	0	597,925	66.00
67.00	06700	OCCUPATIONAL THERAPY	301,898	0	301,898	0	301,898	67.00
68.00	06800	SPEECH PATHOLOGY	41,177	0	41,177	0	41,177	68.00
69.00	06900	ELECTROCARDIOLOGY	29,731		29,731	0	29,731	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	902,482		902,482	0	902,482	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38		38	0	38	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,769,318		2,769,318	0	2,769,318	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,343,054		3,343,054	0	3,343,054	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,966,367		1,966,367		1,966,367	92.00
200.00		Subtotal (see instructions)	25,824,256	0	25,824,256	0	25,824,256	200.00
201.00		Less Observation Beds	1,966,367		1,966,367		1,966,367	201.00
202.00		Total (see instructions)	23,857,889	0	23,857,889	0	23,857,889	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I | Date/Time Prepared: 5/30/2017 10:26 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	2,627,607		2,627,607			30.00
31.00	03100	INTENSIVE CARE UNIT	893,266		893,266			31.00
43.00	04300	NURSERY	202,972		202,972			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	510,271	2,440,176	2,950,447	0.589483	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	91,124	2,939	94,063	2.883110	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	245,682	733,563	979,245	0.292340	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	613,496	14,717,595	15,331,091	0.148413	0.000000	54.00
60.00	06000	LABORATORY	1,118,969	13,471,176	14,590,145	0.200111	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	827,114	782,422	1,609,536	0.471642	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	145,941	2,047,765	2,193,706	0.272564	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	89,449	870,048	959,497	0.314642	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	7,924	110,744	118,668	0.346993	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	269,455	1,884,749	2,154,204	0.013801	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	882,569	1,154,442	2,037,011	0.443042	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	531	531	0.071563	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,813,445	7,712,095	9,525,540	0.290726	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	472,038	14,822,758	15,294,796	0.218575	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,648,999	1,648,999	1.192461	0.000000	92.00
200.00		Subtotal (see instructions)	10,811,322	62,400,002	73,211,324			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,811,322	62,400,002	73,211,324			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I | Date/Time Prepared: 5/30/2017 10:26 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-1317	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Prepared: 5/30/2017 10:26 am
	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	174,069	2,950,447	0.058998	134,101	7,912	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	69,029	94,063	0.733859	0	0	52.00
53.00	05300	ANESTHESIOLOGY	39	979,245	0.000040	48,334	2	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	109,677	15,331,091	0.007154	411,033	2,941	54.00
60.00	06000	LABORATORY	59,801	14,590,145	0.004099	732,837	3,004	60.00
65.00	06500	RESPIRATORY THERAPY	16,601	1,609,536	0.010314	523,642	5,401	65.00
66.00	06600	PHYSICAL THERAPY	26,143	2,193,706	0.011917	64,547	769	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,712	959,497	0.022629	24,474	554	67.00
68.00	06800	SPEECH PATHOLOGY	5,961	118,668	0.050233	7,016	352	68.00
69.00	06900	ELECTROCARDIOLOGY	3,409	2,154,204	0.001582	208,593	330	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	69,069	2,037,011	0.033907	78,944	2,677	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	531	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,949	9,525,540	0.006818	1,459,646	9,952	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	159,687	15,294,796	0.010441	37,939	396	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	117,205	1,648,999	0.071076	0	0	92.00
200.00		Total (lines 50-199)	897,351	69,487,479		3,731,106	34,290	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/30/2017 10:26 am

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	281,762	0	0	0	281,762	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 PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	281,762	0	0	0	281,762	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-1317	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/30/2017 10:26 am
	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	2,950,447	0.000000	0.000000	134,101	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	94,063	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	979,245	0.287734	0.000000	48,334	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,331,091	0.000000	0.000000	411,033	54.00
60.00	06000	LABORATORY	0	14,590,145	0.000000	0.000000	732,837	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,609,536	0.000000	0.000000	523,642	65.00
66.00	06600	PHYSICAL THERAPY	0	2,193,706	0.000000	0.000000	64,547	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	959,497	0.000000	0.000000	24,474	67.00
68.00	06800	SPEECH PATHOLOGY	0	118,668	0.000000	0.000000	7,016	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,154,204	0.000000	0.000000	208,593	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,037,011	0.000000	0.000000	78,944	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	531	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,525,540	0.000000	0.000000	1,459,646	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	15,294,796	0.000000	0.000000	37,939	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,648,999	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	69,487,479			3,731,106	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1317

Period: From 01/01/2016 To 12/31/2016

Worksheet D Part IV

Date/Time Prepared: 5/30/2017 10:26 am

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	13,907	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 PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00		Total (lines 50-199)	13,907	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/30/2017 10:26 am

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	0.589483	0	730,667	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.883110	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.292340	0	172,703	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148413	0	5,103,566	0	0	54.00
60.00	06000	LABORATORY	0.200111	0	5,481,903	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.471642	0	252,797	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.272564	0	849,718	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.314642	0	313,830	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.346993	0	9,357	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.013801	0	926,348	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.443042	0	385,750	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.071563	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.290726	0	3,660,353	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.218575	0	4,944,144	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.192461	0	573,472	0	0	92.00
200.00		Subtotal (see instructions)		0	23,404,608	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	23,404,608	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1317	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/30/2017 10:26 am
	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	430,716	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	50,488	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	757,436	0	54.00
60.00	06000	LABORATORY	1,096,989	0	60.00
65.00	06500	RESPIRATORY THERAPY	119,230	0	65.00
66.00	06600	PHYSICAL THERAPY	231,603	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	98,744	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,247	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12,785	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	170,903	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,064,160	0	73.00
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,080,666	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	683,843	0	92.00
200.00		Subtotal (see instructions)	5,800,810	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	5,800,810	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1317 Component CCN: 15-Z317	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/30/2017 10:26 am
	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	0.589483	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.883110	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.292340	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148413	0	0	0	0	54.00
60.00	06000	LABORATORY	0.200111	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.471642	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.272564	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.314642	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.346993	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.013801	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.443042	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.071563	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.290726	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.218575	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.192461	0	0	0	0	92.00
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: 15-1317 Component CCN: 15-Z317	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/30/2017 10:26 am
	Title XVIII	Swing Beds - SNF	Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	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 PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	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 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V | Date/Time Prepared: 5/30/2017 10:26 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.589483	0	41,571	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.883110	0	50	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.292340	0	12,497	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148413	0	250,732	0	0	54.00
60.00	06000	LABORATORY	0.200111	0	229,498	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.471642	0	13,329	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.272564	0	34,886	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.314642	0	14,822	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.346993	0	1,887	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.013801	0	32,109	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.443042	0	19,676	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.071563	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.290726	0	131,385	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.218575	0	252,523	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.192461	0	25,284	0	0	92.00
200.00		Subtotal (see instructions)		0	1,060,249	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	1,060,249	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1317	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/30/2017 10:26 am
	Title XIX	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	24,505	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	144	0	52.00
53.00	05300	ANESTHESIOLOGY	3,653	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,212	0	54.00
60.00	06000	LABORATORY	45,925	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,287	0	65.00
66.00	06600	PHYSICAL THERAPY	9,509	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,664	0	67.00
68.00	06800	SPEECH PATHOLOGY	655	0	68.00
69.00	06900	ELECTROCARDIOLOGY	443	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,717	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	38,197	0	73.00
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	55,195	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	30,150	0	92.00
200.00		Subtotal (see instructions)	265,256	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	265,256	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/30/2017 10:26 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,148	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,799	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)	1,747	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	349	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,185	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)	349	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	134.05	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)	5,884,147	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)	652,340	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,231,807	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)	5,231,807	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)	1,869.17	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,214,966	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)	2,214,966	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/30/2017 10:26 am

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	1,702,492	364	4,677.18	270	1,262,839	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,046,038	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,523,843	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)	652,340	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)	652,340	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)	1,052	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,869.17	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,966,367	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1317	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/30/2017 10:26 am
	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	350,724	5,884,147	0.059605	1,966,367	117,205	90.00
91.00	Nursing School cost	0	5,884,147	0.000000	1,966,367	0	91.00
92.00	Allied health cost	0	5,884,147	0.000000	1,966,367	0	92.00
93.00	All other Medical Education	0	5,884,147	0.000000	1,966,367	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/30/2017 10:26 am

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		1,561,401		30.00
31.00	03100	INTENSIVE CARE UNIT		594,000		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.589483	134,101	79,050	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.883110	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.292340	48,334	14,130	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148413	411,033	61,003	54.00
60.00	06000	LABORATORY	0.200111	732,837	146,649	60.00
65.00	06500	RESPIRATORY THERAPY	0.471642	523,642	246,972	65.00
66.00	06600	PHYSICAL THERAPY	0.272564	64,547	17,593	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.314642	24,474	7,701	67.00
68.00	06800	SPEECH PATHOLOGY	0.346993	7,016	2,435	68.00
69.00	06900	ELECTROCARDIOLOGY	0.013801	208,593	2,879	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.443042	78,944	34,976	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.071563	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.290726	1,459,646	424,357	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.218575	37,939	8,293	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.192461	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,731,106	1,046,038	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		3,731,106		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1317 | Component CCN: 15-Z317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/30/2017 10:26 am

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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.589483	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.883110	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.292340	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148413	13,445	1,995	54.00
60.00	06000	LABORATORY	0.200111	38,981	7,801	60.00
65.00	06500	RESPIRATORY THERAPY	0.471642	66,376	31,306	65.00
66.00	06600	PHYSICAL THERAPY	0.272564	60,714	16,548	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.314642	58,698	18,469	67.00
68.00	06800	SPEECH PATHOLOGY	0.346993	303	105	68.00
69.00	06900	ELECTROCARDIOLOGY	0.013801	3,579	49	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.443042	55,779	24,712	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.071563	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.290726	149,198	43,376	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.218575	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.192461	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		447,073	144,361	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)		447,073		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1317	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/30/2017 10:26 am
	Title XIX	Hospital	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		40,170		30.00
31.00	03100	INTENSIVE CARE UNIT		11,923		31.00
43.00	04300	NURSERY		2,709		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.589483	6,811	4,015	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.883110	1,216	3,506	52.00
53.00	05300	ANESTHESIOLOGY	0.292340	3,279	959	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148413	8,188	1,215	54.00
60.00	06000	LABORATORY	0.200111	14,935	2,989	60.00
65.00	06500	RESPIRATORY THERAPY	0.471642	11,040	5,207	65.00
66.00	06600	PHYSICAL THERAPY	0.272564	1,948	531	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.314642	1,194	376	67.00
68.00	06800	SPEECH PATHOLOGY	0.346993	106	37	68.00
69.00	06900	ELECTROCARDIOLOGY	0.013801	3,596	50	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.443042	11,780	5,219	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.071563	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.290726	24,204	7,037	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.218575	6,300	1,377	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.192461	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		94,597	32,518	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)		94,597		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part B Date/Time Prepared: 5/30/2017 10:26 am

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,800,810	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)	5,800,810	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)	5,858,818	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)	38,988	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,615,540	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)	2,204,290	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)	2,204,290	30.00
31.00	Primary payer payments	1,275	31.00
32.00	Subtotal (line 30 minus line 31)	2,203,015	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)	896,623	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	582,805	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	705,913	36.00
37.00	Subtotal (see instructions)	2,785,820	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)	2,785,820	40.00
40.01	Sequestration adjustment (see instructions)	55,716	40.01
41.00	Interim payments	3,361,626	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-631,522	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: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I Date/Time Prepared: 5/30/2017 10:26 am

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		3,889,441		3,361,626	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	07/01/2016	72,000		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)		72,000		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,961,441		3,361,626	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		154,191		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		631,522	6.02
7.00	Total Medicare program liability (see instructions)		4,115,632		2,730,104	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: 15-1317 | Component CCN: 15-Z317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2017 10:26 am

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		722,369		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)		722,369		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		61,314		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		783,683		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: 15-1317	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/30/2017 10:26 am
	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	716	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,455	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	58	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	2,111	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	73,211,324	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	438,479	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: 15-1317 Component CCN: 15-Z317	Period: From 01/01/2016 To 12/31/2016	Worksheet E-2 Date/Time Prepared: 5/30/2017 10:26 am
	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)	658,863	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)	145,805	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	349	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)	804,668	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	804,668	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)	804,668	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,991	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)	799,677	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)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	799,677	0	19.00
19.01	Sequestration adjustment (see instructions)	15,994	0	19.01
20.00	Interim payments	722,369	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)	61,314	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	Provider CCN: 15-1317	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part V Date/Time Prepared: 5/30/2017 10:26 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,523,843	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)	4,523,843	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,569,081	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)	4,569,081	19.00
20.00	Deductibles (exclude professional component)	431,424	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,137,657	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	4,137,657	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	95,334	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	61,967	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	63,028	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,199,624	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)	4,199,624	30.00
30.01	Sequestration adjustment (see instructions)	83,992	30.01
31.00	Interim payments	3,961,441	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)	154,191	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: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-3 Part VII Date/Time Prepared: 5/30/2017 10:26 am

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		265,256	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	265,256	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	265,256	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	94,597	1,060,249	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	94,597	1,060,249	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	94,597	1,060,249	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	94,597	794,993	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	265,256	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	265,256	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	265,256	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	265,256	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	265,256	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	265,256	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	265,256	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)	Provider CCN: 15-1317	Period: From 01/01/2016 To 12/31/2016	Worksheet G Date/Time Prepared: 5/30/2017 10:26 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	589,343	0	0	0	1.00
2.00	Temporary investments	1,131,553	0	0	0	2.00
3.00	Notes receivable	1,695,724	0	0	0	3.00
4.00	Accounts receivable	5,530,290	0	0	0	4.00
5.00	Other receivable	-967,539	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	261,665	0	0	0	7.00
8.00	Prepaid expenses	2,036,004	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	10,277,040	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	651,198	0	0	0	12.00
13.00	Land improvements	335,729	0	0	0	13.00
14.00	Accumulated depreciation	-94,935	0	0	0	14.00
15.00	Buildings	7,117,370	0	0	0	15.00
16.00	Accumulated depreciation	-2,670,047	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	3,697,952	0	0	0	19.00
20.00	Accumulated depreciation	-971,274	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	2,334,434	0	0	0	23.00
24.00	Accumulated depreciation	-1,275,263	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)	9,125,164	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	890,343	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	32,208	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	922,551	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	20,324,755	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,324,688	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,674,344	0	0	0	38.00
39.00	Payroll taxes payable	136,531	0	0	0	39.00
40.00	Notes and loans payable (short term)	384,186	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	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,519,749	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	9,434,570	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9,434,570	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,954,319	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	7,370,436				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)	7,370,436	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	20,324,755	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 5/30/2017 10:26 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		6,618,430		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,595,121				2.00
3.00	Total (sum of line 1 and line 2)		8,213,551		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)		8,213,551		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		8,213,551		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	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1317 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/30/2017 10:26 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,541,591		2,541,591	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,541,591		2,541,591	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	893,266		893,266	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)	893,266		893,266	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,434,857		3,434,857	17.00
18.00	Ancillary services	7,628,333	62,477,243	70,105,576	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,063,190	62,477,243	73,540,433	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		26,332,797		29.00
30.00	BAD DEBT NOT ON WORKSHEET A	5,444,060			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)		5,444,060		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)		31,776,857		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1317	Period: From 01/01/2016 To 12/31/2016	Worksheet G-3 Date/Time Prepared: 5/30/2017 10:26 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	73,540,433	1.00
2.00	Less contractual allowances and discounts on patients' accounts	41,311,742	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,228,691	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,776,857	4.00
5.00	Net income from service to patients (line 3 minus line 4)	451,834	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANTS, PUCH DISC, RENT INCOME	1,143,287	24.00
25.00	Total other income (sum of lines 6-24)	1,143,287	25.00
26.00	Total (line 5 plus line 25)	1,595,121	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)	1,595,121	29.00