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: 15-1328	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/24/2017 8:39 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/24/2017 Time: 8:39 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 INDIANA UNIVERSITY HEALTH BEDFORD (15-1328) 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)

CHIEF FINANCIAL OFFICER
Title

05/24/2017
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	780,057	198,645	0	0	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	-6,291	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	773,766	198,645	0	0	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: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2017 10:55 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2900 WEST SIXTEENTH STREET	PO Box:			1.00
2.00	City: BEDFORD	State: IN	Zip Code: 47421-	County: LAWRENCE	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	INDIANA UNIVERSITY HEALTH BEDFORD	151328	99915	1	10/01/2005	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	IU HEALTH BEDFORD - SWING BED	15Z328	99915		10/01/2005	N	O	O	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: 1.00	To: 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)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2017 10:55 am

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2017 10:55 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: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2017 10:55 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	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	85,888	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: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2017 10:55 am

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	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: INDIANA UNIVERSITY HEALTH, INC	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST 10TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46202	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	Y	Y	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	Y	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: 15-1328	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/23/2017 10:55 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)	10/01/2016	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)	Y	214	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 5/23/2017 10:55 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/10/2017	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/03/2017	Y	04/03/2017	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: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 5/23/2017 10:55 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	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	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.	RHONDA	UTTER	41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-962-1093	RUTTER@IUHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1328	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/23/2017 10:55 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.	DIRECTOR		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: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/23/2017 10:55 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	19	6,954	56,088.00	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)		19	6,954	56,088.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,196	13,104.00	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						13.00
14.00	Total (see instructions)		25	9,150	69,192.00	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: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/23/2017 10:55 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)	1,437	33	2,337			1.00
2.00	HMO and other (see instructions)	621	279				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	416	0	416			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	211			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,853	33	2,964			7.00
8.00	INTENSIVE CARE UNIT	492	11	546			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)	2,345	44	3,510	0.00	209.00	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	15			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	209.00	27.00
28.00	Observation Bed Days		251	1,494			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/23/2017 10:55 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	529	12	965	1.00
2.00	HMO and other (see instructions)			133	85		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	529	12	965	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: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 5/23/2017 10:55 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)	0.252989	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,535,281	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	29,490,635	6.00
7.00	Medicaid cost (line 1 times line 6)	7,460,806	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,925,525	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)	2,925,525	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)	2,908,599	91,672	3,000,271	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	735,844	23,192	759,036	21.00
22.00	Partial payment by patients approved for charity care	78,545	13,547	92,092	22.00
23.00	Cost of charity care (line 21 minus line 22)	657,299	9,645	666,944	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,838,238	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	915,060	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,923,178	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	486,543	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,153,487	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,079,012	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/23/2017 10:55 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	NEW CAP REL COSTS-BLDG & FIXT		0	0	759,831	759,831	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	1,200,241	1,200,241	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	11,151	99,273	110,424	2,074,135	2,184,559	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,173,239	9,152,278	10,325,517	-531,082	9,794,435	5.00
7.00	00700	OPERATION OF PLANT	359,501	1,669,853	2,029,354	-280,384	1,748,970	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,015	3,015	-1,266	1,749	8.00
9.00	00900	HOUSEKEEPING	356,704	351,442	708,146	-136,972	571,174	9.00
10.00	01000	DIETARY	349,618	269,963	619,581	-290,951	328,630	10.00
11.00	01100	CAFETERIA	0	0	0	204,582	204,582	11.00
13.00	01300	NURSING ADMINISTRATION	1,197,857	308,154	1,506,011	-179,957	1,326,054	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	47,186	206,635	253,821	-29,314	224,507	14.00
15.00	01500	PHARMACY	401,382	7,245,025	7,646,407	-7,065,209	581,198	15.00
17.00	01700	SOCIAL SERVICE	0	0	0	52,995	52,995	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,299,148	628,340	2,927,488	-350,630	2,576,858	30.00
31.00	03100	INTENSIVE CARE UNIT	970,433	333,251	1,303,684	-232,703	1,070,981	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,592,281	1,119,412	2,711,693	-596,711	2,114,982	50.00
51.00	05100	RECOVERY ROOM	70,941	21,376	92,317	-16,247	76,070	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,826,449	1,564,597	3,391,046	-756,518	2,634,528	54.00
56.00	05600	RADIOISOTOPE	87,898	280,959	368,857	-193,287	175,570	56.00
60.00	06000	LABORATORY	275,067	3,975,400	4,250,467	-114,790	4,135,677	60.00
66.00	06600	PHYSICAL THERAPY	967,224	201,044	1,168,268	-120,593	1,047,675	66.00
69.00	06900	ELECTROCARDIOLOGY	835,219	681,556	1,516,775	-236,229	1,280,546	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	125,001	125,001	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	105,551	105,551	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,157,546	7,157,546	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	58,932	58,932	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	39,449	48,785	88,234	-6,203	82,031	90.01
91.00	09100	EMERGENCY	1,584,345	1,267,199	2,851,544	-268,996	2,582,548	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,445,092	29,427,557	43,872,649	330,772	44,203,421	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,458	11,927	22,385	-10,972	11,413	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	268,902	268,902	-268,901	1	192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	0	46,254	46,254	-5,174	41,080	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	146,113	59,607	205,720	-45,684	160,036	194.02
194.03	07953	HOME CARE	0	41	41	-41	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	14,601,663	29,814,288	44,415,951	0	44,415,951	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/23/2017 10:55 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	135,119	894,950		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	15,104	1,215,345		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-54,178	2,130,381		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,908,832	11,703,267		5.00
7.00	00700	OPERATION OF PLANT	-17,422	1,731,548		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-513	1,236		8.00
9.00	00900	HOUSEKEEPING	-808	570,366		9.00
10.00	01000	DIETARY	0	328,630		10.00
11.00	01100	CAFETERIA	-99,383	105,199		11.00
13.00	01300	NURSING ADMINISTRATION	-11,789	1,314,265		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	224,507		14.00
15.00	01500	PHARMACY	0	581,198		15.00
17.00	01700	SOCIAL SERVICE	0	52,995		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,576,858		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,070,981		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-831,186	1,283,796		50.00
51.00	05100	RECOVERY ROOM	-2,597	73,473		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-5,838	2,628,690		54.00
56.00	05600	RADIOISOTOPE	0	175,570		56.00
60.00	06000	LABORATORY	-274,877	3,860,800		60.00
66.00	06600	PHYSICAL THERAPY	-1,509	1,046,166		66.00
69.00	06900	ELECTROCARDIOLOGY	-39,276	1,241,270		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	125,001		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	105,551		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,157,546		73.00
76.97	07697	CARDIAC REHABILITATION	0	58,932		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC - DIABETES	0	82,031		90.01
91.00	09100	EMERGENCY	-175,265	2,407,283		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	544,414	44,747,835		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,413		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1		192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	0	41,080		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	160,036		194.02
194.03	07953	HOME CARE	0	0		194.03
200.00		TOTAL (SUM OF LINES 118-199)	544,414	44,960,365		200.00

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/23/2017 10:55 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,075,929	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
	0		0	2,075,929	
	B - DIETARY/CAFETERIA				
1.00	CAFETERIA	11.00	134,141	70,441	1.00
	0		134,141	70,441	
	C - CAPITAL LEASE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	2,995	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	17,169	2.00
3.00		0.00	0	0	3.00
	0		0	20,164	
	D - CARDIOLOGY				
1.00	CARDIAC REHABILITATION	76.97	50,877	8,055	1.00
	0		50,877	8,055	
	E - MME DEPR EXPENSE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	666,587	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	1,175,647	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	0		0	1,842,234	
	F - BILLABLE DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,157,546	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/23/2017 10:55 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	0		0	7,157,546		
	G - IMPLANT SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	105,551		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	105,551		
	H - MARKETING					
1.00	MARKETING/PUBLIC RELATIONS	194.00	0	4,443		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	4,443		
	I - BILLABLE MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	408		1.00
2.00	PHARMACY	15.00	0	18,504		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	924		3.00
4.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	125,001		4.00
5.00	EMERGENCY	91.00	0	143		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	0		0	144,980		
	J - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	37,768		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	7,425		2.00
	0		0	45,193		
	K - PROPERTY TAXES					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	52,481		1.00
	0		0	52,481		
	L - SOCIAL WORKER					
1.00	SOCIAL SERVICE	17.00	52,995	0		1.00
	0		52,995	0		
500.00	Grand Total: Increases		238,013	11,527,017		500.00

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/23/2017 10:55 am

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	126,050	0	1.00
2.00	OPERATION OF PLANT	7.00	0	44,251	0	2.00
3.00	HOUSEKEEPING	9.00	0	135,140	0	3.00
4.00	DIETARY	10.00	0	68,682	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	169,057	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	12,631	0	6.00
7.00	PHARMACY	15.00	0	47,822	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	309,303	0	8.00
9.00	INTENSIVE CARE UNIT	31.00	0	143,316	0	9.00
10.00	OPERATING ROOM	50.00	0	163,958	0	10.00
11.00	RECOVERY ROOM	51.00	0	15,982	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	293,913	0	12.00
13.00	RADIOISOTOPE	56.00	0	13,516	0	13.00
14.00	LABORATORY	60.00	0	21,432	0	14.00
15.00	PHYSICAL THERAPY	66.00	0	107,025	0	15.00
16.00	ELECTROCARDIOLOGY	69.00	0	128,942	0	16.00
17.00	CLINIC - DIABETES	90.01	0	6,009	0	17.00
18.00	EMERGENCY	91.00	0	224,367	0	18.00
19.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	10,972	0	19.00
20.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	42	0	20.00
21.00	MARKETING/PUBLIC RELATIONS	194.00	0	48	0	21.00
22.00	BLOOMNGTN AMBULANCE AND OCC MED	194.02	0	33,471	0	22.00
	0		0	2,075,929		
	B - DIETARY/CAFETERIA					
1.00	DIETARY	10.00	134,141	70,441	0	1.00
	0		134,141	70,441		
	C - CAPITAL LEASE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,519	9	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,476	9	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	17,169	0	3.00
	0		0	20,164		
	D - CARDIOLOGY					
1.00	ELECTROCARDIOLOGY	69.00	50,877	8,055	0	1.00
	0		50,877	8,055		
	E - MME DEPR EXPENSE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,794	9	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	247,546	9	2.00
3.00	OPERATION OF PLANT	7.00	0	236,133	0	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	1,266	0	4.00
5.00	HOUSEKEEPING	9.00	0	1,832	0	5.00
6.00	DIETARY	10.00	0	17,687	0	6.00
7.00	NURSING ADMINISTRATION	13.00	0	10,900	0	7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	14,705	0	8.00
9.00	PHARMACY	15.00	0	16,759	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	0	38,393	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	0	90,311	0	11.00
12.00	OPERATING ROOM	50.00	0	202,709	0	12.00
13.00	RECOVERY ROOM	51.00	0	265	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	402,279	0	14.00
15.00	RADIOISOTOPE	56.00	0	87,033	0	15.00
16.00	LABORATORY	60.00	0	93,358	0	16.00
17.00	PHYSICAL THERAPY	66.00	0	12,778	0	17.00
18.00	ELECTROCARDIOLOGY	69.00	0	48,085	0	18.00
19.00	CLINIC - DIABETES	90.01	0	194	0	19.00
20.00	EMERGENCY	91.00	0	44,694	0	20.00
21.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	251,690	0	21.00
22.00	MARKETING/PUBLIC RELATIONS	194.00	0	9,569	0	22.00
23.00	BLOOMNGTN AMBULANCE AND OCC MED	194.02	0	12,213	0	23.00
24.00	HOME CARE	194.03	0	41	0	24.00
	0		0	1,842,234		
	F - BILLABLE DRUGS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	350	0	1.00
2.00	PHARMACY	15.00	0	7,019,115	0	2.00
3.00	OPERATING ROOM	50.00	0	141	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	46,420	0	4.00
5.00	RADIOISOTOPE	56.00	0	91,218	0	5.00
6.00	PHYSICAL THERAPY	66.00	0	16	0	6.00
7.00	ELECTROCARDIOLOGY	69.00	0	209	0	7.00
8.00	EMERGENCY	91.00	0	77	0	8.00
	0		0	7,157,546		

RECLASSIFICATIONS | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/23/2017 10:55 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	G - IMPLANT SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,386	0		1.00
2.00	OPERATING ROOM	50.00	0	103,164	0		2.00
3.00	EMERGENCY	91.00	0	1	0		3.00
	0		0	105,551			
	H - MARKETING						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,385	0		1.00
2.00	PHARMACY	15.00	0	17	0		2.00
3.00	OPERATING ROOM	50.00	0	41	0		3.00
	0		0	4,443			
	I - BILLABLE MEDICAL SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	563	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	2,934	0		2.00
3.00	OPERATING ROOM	50.00	0	126,698	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	12,430	0		4.00
5.00	RADIOISOTOPE	56.00	0	1,520	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	774	0		6.00
7.00	ELECTROCARDIOLOGY	69.00	0	61	0		7.00
	0		0	144,980			
	J - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	45,193	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	45,193			
	K - PROPERTY TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	52,481	9		1.00
	0		0	52,481			
	L - SOCIAL WORKER						
1.00	ADMINISTRATIVE & GENERAL	5.00	52,995	0	0		1.00
	0		52,995	0			
500.00	Grand Total: Decreases		238,013	11,527,017			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 5/23/2017 10:55 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	931,334	0	0	0	0	1.00
2.00	Land Improvements	1,174,400	0	0	0	54,665	2.00
3.00	Buildings and Fixtures	14,929,250	0	0	0	0	3.00
4.00	Building Improvements	3,761,928	1,269,417	0	1,269,417	3,720	4.00
5.00	Fixed Equipment	242,674	0	0	0	242,674	5.00
6.00	Movable Equipment	20,595,178	778,416	0	778,416	258,731	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	41,634,764	2,047,833	0	2,047,833	559,790	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	41,634,764	2,047,833	0	2,047,833	559,790	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	931,334	0	1.00
2.00	Land Improvements	1,119,735	0	2.00
3.00	Buildings and Fixtures	14,929,250	0	3.00
4.00	Building Improvements	5,027,625	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	21,114,863	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	43,122,807	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	43,122,807	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part II Date/Time Prepared: 5/23/2017 10:55 am

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

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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 5/23/2017 10:55 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	22,007,943	639,150	21,368,793	0.506355	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	21,114,864	282,456	20,832,408	0.493645	0	2.00
3.00	Total (sum of lines 1-2)	43,122,807	921,606	42,201,201	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	912,119	-17,169	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,218,340	-2,995	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,130,459	-20,164	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	894,950	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,215,345	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	2,110,295	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/23/2017 10:55 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-17,169	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-2,995	NEW CAP REL COSTS-MVBLE EQUIP	2.00	10	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,721,722			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	6,542,128			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-187,535	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/23/2017 10:55 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	MISCELLANEOUS INCOME	B	-18,669	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	MISCELLANEOUS INCOME	B	-2,567	OPERATION OF PLANT	7.00	0	34.00
35.00	MISCELLANEOUS INCOME	B	-513	LAUNDRY & LINEN SERVICE	8.00	0	35.00
37.00	MISCELLANEOUS INCOME	B	-808	HOUSEKEEPING	9.00	0	37.00
38.00	MISCELLANEOUS INCOME	B	-99,383	CAFETERIA	11.00	0	38.00
39.00	MISCELLANEOUS INCOME	B	-11,789	NURSING ADMINISTRATION	13.00	0	39.00
40.00	MISCELLANEOUS INCOME	B	-2,597	RECOVERY ROOM	51.00	0	40.00
41.00	MISCELLANEOUS INCOME	B	-5,838	RADIOLOGY-DIAGNOSTIC	54.00	0	41.00
42.00	MISCELLANEOUS INCOME	B	-23	PHYSICAL THERAPY	66.00	0	42.00
43.00	MISCELLANEOUS INCOME	B	-39,146	ELECTROCARDIOLOGY	69.00	0	43.00
45.00	INVESTMENT FEES	B	7,169	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	BENEFITS	A	-2,085,362	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.01
45.02	PHONES	A	-1,788	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.02
45.03	PHONES	A	-4,047	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	45.03
45.04	PHONES	A	-5,860	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.04
45.05	PHONES	A	-20,019	ADMINISTRATIVE & GENERAL	5.00	9	45.05
45.06	HAF	A	-722,271	ADMINISTRATIVE & GENERAL	5.00	9	45.06
45.07	RECRUITING	A	-38,441	ADMINISTRATIVE & GENERAL	5.00	0	45.07
45.08	CABLE	A	-14,855	OPERATION OF PLANT	7.00	0	45.08
45.09	CABLE	A	-1,486	PHYSICAL THERAPY	66.00	0	45.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		544,414				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/23/2017 10:55 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HO ALLOCATIONS CAPITAL COSTS	154,076	0	1.00
2.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	HO ALLOCATIONS CAPITAL COSTS	209,681	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HO ALLOCATIONS EMPLOYEE BENE	2,037,044	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	BLOOMINGTION ADMIN ALLOC	3,523,754	0	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	HO ALLOCATION CORPORATE ADMI	6,419,477	7,242,168	3.02
4.00	5.00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	413,714	413,714	4.00
4.01	7.00	OPERATION OF PLANT	SHARED EMPLOYEES	19,789	19,789	4.01
4.02	10.00	DIETARY	SHARED EMPLOYEES	2,960	2,960	4.02
4.04	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	317,177	317,177	4.04
4.05	31.00	INTENSIVE CARE UNIT	SHARED EMPLOYEES	79,294	79,294	4.05
4.06	60.00	LABORATORY	SHARED EMPLOYEES	3,699,272	3,699,272	4.06
4.07	66.00	PHYSICAL THERAPY	SHARED EMPLOYEES	53,564	53,564	4.07
4.08	69.00	ELECTROCARDIOLOGY	SHARED EMPLOYEES	314,818	314,818	4.08
4.09	90.01	CLINIC - DIABETES	SHARED EMPLOYEES	36,558	36,558	4.09
4.10	91.00	EMERGENCY	BLOOMINGTON ER	2,165,546	725,282	4.10
5.00	0		0	19,446,724	12,904,596	5.00

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

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

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

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

6.00	B		0.00	IU HEALTH, INC.	50.00	6.00
7.00	F		0.00	IUH BLOOMINGTO	50.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/23/2017 10:55 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	154,076	9		1.00
2.00	209,681	9		2.00
3.00	2,037,044	0		3.00
3.01	3,523,754	0		3.01
3.02	-822,691	0		3.02
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	1,440,264	0		4.10
5.00	6,542,128			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	HEALTHCARE		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 5/23/2017 10:55 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	5.00	ADMINISTRATIVE & GENERAL	78,750	0	78,750	0	0	1.00
2.00	50.00	OPERATING ROOM	831,186	831,186	0	0	0	2.00
3.00	60.00	LABORATORY	274,877	274,877	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	34,580	130	34,450	0	0	4.00
5.00	91.00	EMERGENCY	2,165,546	1,615,529	550,017	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,384,939	2,721,722	663,217		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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0		1.00
2.00	50.00	OPERATING ROOM	0	0	0	831,186		2.00
3.00	60.00	LABORATORY	0	0	0	274,877		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	130		4.00
5.00	91.00	EMERGENCY	0	0	0	1,615,529		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	2,721,722		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/23/2017 10:55 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	894,950	894,950				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,215,345		1,215,345			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,130,381	2,355	4,448	2,137,184		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,703,267	140,439	265,276	164,091	12,273,073	5.00
7.00	00700	OPERATION OF PLANT	1,731,548	94,389	178,293	52,659	2,056,889	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,236	0	0	0	1,236	8.00
9.00	00900	HOUSEKEEPING	570,366	11,824	22,335	52,249	656,774	9.00
10.00	01000	DIETARY	328,630	18,283	34,535	31,563	413,011	10.00
11.00	01100	CAFETERIA	105,199	11,385	21,506	19,649	157,739	11.00
13.00	01300	NURSING ADMINISTRATION	1,314,265	23,722	44,809	175,460	1,558,256	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	224,507	4,816	9,096	6,912	245,331	14.00
15.00	01500	PHARMACY	581,198	6,648	12,558	58,794	659,198	15.00
17.00	01700	SOCIAL SERVICE	52,995	0	0	7,763	60,758	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,576,858	52,467	99,106	336,769	3,065,200	30.00
31.00	03100	INTENSIVE CARE UNIT	1,070,981	14,608	27,593	142,147	1,255,329	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,283,796	68,419	129,237	233,234	1,714,686	50.00
51.00	05100	RECOVERY ROOM	73,473	0	0	10,391	83,864	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,628,690	70,829	133,789	267,535	3,100,843	54.00
56.00	05600	RADIOISOTOPE	175,570	0	0	12,875	188,445	56.00
60.00	06000	LABORATORY	3,860,800	21,737	41,059	40,291	3,963,887	60.00
66.00	06600	PHYSICAL THERAPY	1,046,166	21,898	41,364	141,677	1,251,105	66.00
69.00	06900	ELECTROCARDIOLOGY	1,241,270	24,438	46,160	114,889	1,426,757	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	125,001	0	0	0	125,001	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	105,551	0	0	0	105,551	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,157,546	0	0	0	7,157,546	73.00
76.97	07697	CARDIAC REHABILITATION	58,932	10,324	19,500	7,452	96,208	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	82,031	2,419	4,570	5,778	94,798	90.01
91.00	09100	EMERGENCY	2,407,283	24,959	47,146	232,072	2,711,460	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)	44,747,835	625,959	1,182,380	2,114,250	44,422,945	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,413	4,298	8,119	1,532	25,362	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1	221,598	0	0	221,599	192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	41,080	13,154	24,846	0	79,080	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	160,036	29,941	0	21,402	211,379	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	44,960,365	894,950	1,215,345	2,137,184	44,960,365	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/23/2017 10:55 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,273,073					5.00
7.00	00700	OPERATION OF PLANT	772,298	2,829,187				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	464	0	1,700			8.00
9.00	00900	HOUSEKEEPING	246,598	50,858	0	954,230		9.00
10.00	01000	DIETARY	155,073	78,640	0	44,235	690,959	10.00
11.00	01100	CAFETERIA	59,226	48,971	0	27,546	0	11.00
13.00	01300	NURSING ADMINISTRATION	585,077	102,033	0	57,393	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	92,114	20,712	0	11,651	0	14.00
15.00	01500	PHARMACY	247,508	28,596	0	16,085	0	15.00
17.00	01700	SOCIAL SERVICE	22,813	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,150,888	225,672	660	126,940	560,108	30.00
31.00	03100	INTENSIVE CARE UNIT	471,337	62,832	330	35,343	130,851	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	643,811	294,284	409	165,534	0	50.00
51.00	05100	RECOVERY ROOM	31,488	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,164,270	304,650	0	171,366	0	54.00
56.00	05600	RADIOISOTOPE	70,755	0	0	0	0	56.00
60.00	06000	LABORATORY	1,488,317	93,494	0	52,590	0	60.00
66.00	06600	PHYSICAL THERAPY	469,751	94,189	0	52,981	0	66.00
69.00	06900	ELECTROCARDIOLOGY	535,703	105,111	0	59,125	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	46,934	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	39,631	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,687,446	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	36,123	44,404	0	24,977	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	35,594	10,406	0	5,853	0	90.01
91.00	09100	EMERGENCY	1,018,069	107,355	301	60,387	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)	12,071,288	1,672,207	1,700	912,006	690,959	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,523	18,488	0	10,400	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	83,204	953,132	0	0	0	192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	29,692	56,577	0	31,824	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	79,366	128,783	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	12,273,073	2,829,187	1,700	954,230	690,959	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/23/2017 10:55 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	SOCIAL SERVICE	
			11.00	13.00	14.00	15.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	293,482					11.00
13.00	01300	NURSING ADMINISTRATION	22,846	2,325,605				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,515	0	373,323			14.00
15.00	01500	PHARMACY	8,787	0	0	960,174		15.00
17.00	01700	SOCIAL SERVICE	1,757	0	0	0	85,328	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	61,509	980,677	0	0	69,168	30.00
31.00	03100	INTENSIVE CARE UNIT	19,331	308,213	0	0	16,160	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,089	336,232	0	0	0	50.00
51.00	05100	RECOVERY ROOM	1,757	28,019	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	49,207	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	1,757	0	0	0	0	56.00
60.00	06000	LABORATORY	1,757	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	22,846	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	21,089	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	202,409	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	170,914	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	960,174	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,757	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	1,757	0	0	0	0	90.01
91.00	09100	EMERGENCY	42,177	672,464	0	0	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)	282,938	2,325,605	373,323	960,174	85,328	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,757	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	8,787	0	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	293,482	2,325,605	373,323	960,174	85,328	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/23/2017 10:55 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
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
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	6,240,822	0	6,240,822		30.00
31.00	03100	INTENSIVE CARE UNIT	2,299,726	0	2,299,726		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,176,045	0	3,176,045		50.00
51.00	05100	RECOVERY ROOM	145,128	0	145,128		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,790,336	0	4,790,336		54.00
56.00	05600	RADIOISOTOPE	260,957	0	260,957		56.00
60.00	06000	LABORATORY	5,600,045	0	5,600,045		60.00
66.00	06600	PHYSICAL THERAPY	1,890,872	0	1,890,872		66.00
69.00	06900	ELECTROCARDIOLOGY	2,147,785	0	2,147,785		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	374,344	0	374,344		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	316,096	0	316,096		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,805,166	0	10,805,166		73.00
76.97	07697	CARDIAC REHABILITATION	203,469	0	203,469		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	CLINIC - DIABETES	148,408	0	148,408		90.01
91.00	09100	EMERGENCY	4,612,213	0	4,612,213		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)	43,011,412	0	43,011,412		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	65,530	0	65,530		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,257,935	0	1,257,935		192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	197,173	0	197,173		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	428,315	0	428,315		194.02
194.03	07953	HOME CARE	0	0	0		194.03
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	44,960,365	0	44,960,365		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/23/2017 10:55 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,355	4,448	6,803	6,803	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	140,439	265,276	405,715	522	5.00
7.00	00700	OPERATION OF PLANT	0	94,389	178,293	272,682	168	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	11,824	22,335	34,159	166	9.00
10.00	01000	DIETARY	0	18,283	34,535	52,818	100	10.00
11.00	01100	CAFETERIA	0	11,385	21,506	32,891	63	11.00
13.00	01300	NURSING ADMINISTRATION	0	23,722	44,809	68,531	558	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,816	9,096	13,912	22	14.00
15.00	01500	PHARMACY	0	6,648	12,558	19,206	187	15.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	25	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	52,467	99,106	151,573	1,075	30.00
31.00	03100	INTENSIVE CARE UNIT	0	14,608	27,593	42,201	452	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	68,419	129,237	197,656	742	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	33	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	70,829	133,789	204,618	851	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	41	56.00
60.00	06000	LABORATORY	0	21,737	41,059	62,796	128	60.00
66.00	06600	PHYSICAL THERAPY	0	21,898	41,364	63,262	451	66.00
69.00	06900	ELECTROCARDIOLOGY	0	24,438	46,160	70,598	366	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	10,324	19,500	29,824	24	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	0	2,419	4,570	6,989	18	90.01
91.00	09100	EMERGENCY	0	24,959	47,146	72,105	738	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	625,959	1,182,380	1,808,339	6,730	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,298	8,119	12,417	5	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	221,598	0	221,598	0	192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	0	13,154	24,846	38,000	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	29,941	0	29,941	68	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	894,950	1,215,345	2,110,295	6,803	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/23/2017 10:55 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	406,237					5.00
7.00	00700	OPERATION OF PLANT	25,563	298,413				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15	0	15			8.00
9.00	00900	HOUSEKEEPING	8,162	5,364	0	47,851		9.00
10.00	01000	DIETARY	5,133	8,295	0	2,218	68,564	10.00
11.00	01100	CAFETERIA	1,960	5,165	0	1,381	0	11.00
13.00	01300	NURSING ADMINISTRATION	19,366	10,762	0	2,878	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,049	2,185	0	584	0	14.00
15.00	01500	PHARMACY	8,193	3,016	0	807	0	15.00
17.00	01700	SOCIAL SERVICE	755	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,094	23,803	5	6,366	55,580	30.00
31.00	03100	INTENSIVE CARE UNIT	15,601	6,627	3	1,772	12,984	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,310	31,040	4	8,301	0	50.00
51.00	05100	RECOVERY ROOM	1,042	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,537	32,133	0	8,593	0	54.00
56.00	05600	RADIOISOTOPE	2,342	0	0	0	0	56.00
60.00	06000	LABORATORY	49,263	9,861	0	2,637	0	60.00
66.00	06600	PHYSICAL THERAPY	15,549	9,935	0	2,657	0	66.00
69.00	06900	ELECTROCARDIOLOGY	17,732	11,087	0	2,965	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,554	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,312	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	88,954	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,196	4,684	0	1,252	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	1,178	1,098	0	294	0	90.01
91.00	09100	EMERGENCY	33,698	11,323	3	3,028	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)	399,558	176,378	15	45,733	68,564	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	315	1,950	0	522	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,754	100,533	0	0	0	192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	983	5,968	0	1,596	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	2,627	13,584	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	406,237	298,413	15	47,851	68,564	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/23/2017 10:55 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	SOCIAL SERVICE	
			11.00	13.00	14.00	15.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	41,460					11.00
13.00	01300	NURSING ADMINISTRATION	3,227	105,322				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	497	0	20,249			14.00
15.00	01500	PHARMACY	1,241	0	0	32,650		15.00
17.00	01700	SOCIAL SERVICE	248	0	0	0	1,028	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,693	44,413	0	0	833	30.00
31.00	03100	INTENSIVE CARE UNIT	2,731	13,958	0	0	195	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,979	15,227	0	0	0	50.00
51.00	05100	RECOVERY ROOM	248	1,269	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,951	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	248	0	0	0	0	56.00
60.00	06000	LABORATORY	248	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	3,227	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,979	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	10,979	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	9,270	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	32,650	0	73.00
76.97	07697	CARDIAC REHABILITATION	248	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	248	0	0	0	0	90.01
91.00	09100	EMERGENCY	5,958	30,455	0	0	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)	39,971	105,322	20,249	32,650	1,028	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	248	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	1,241	0	0	0	0	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	41,460	105,322	20,249	32,650	1,028	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/23/2017 10:55 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
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
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	330,435	0	330,435		30.00
31.00	03100	INTENSIVE CARE UNIT	96,524	0	96,524		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	277,259	0	277,259		50.00
51.00	05100	RECOVERY ROOM	2,592	0	2,592		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	291,683	0	291,683		54.00
56.00	05600	RADIOISOTOPE	2,631	0	2,631		56.00
60.00	06000	LABORATORY	124,933	0	124,933		60.00
66.00	06600	PHYSICAL THERAPY	95,081	0	95,081		66.00
69.00	06900	ELECTROCARDIOLOGY	105,727	0	105,727		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,533	0	12,533		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,582	0	10,582		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	121,604	0	121,604		73.00
76.97	07697	CARDIAC REHABILITATION	37,228	0	37,228		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	CLINIC - DIABETES	9,825	0	9,825		90.01
91.00	09100	EMERGENCY	157,308	0	157,308		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)	1,675,945	0	1,675,945		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,457	0	15,457		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	324,885	0	324,885		192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	46,547	0	46,547		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	47,461	0	47,461		194.02
194.03	07953	HOME CARE	0	0	0		194.03
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	2,110,295	0	2,110,295		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/23/2017 10:55 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW 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	NEW CAP REL COSTS-BLDG & FIXT	193,839					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		139,358				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	510	510	14,590,512			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,418	30,418	1,120,244	-12,273,073	32,687,292	5.00
7.00	00700	OPERATION OF PLANT	20,444	20,444	359,501	0	2,056,889	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	1,236	8.00
9.00	00900	HOUSEKEEPING	2,561	2,561	356,704	0	656,774	9.00
10.00	01000	DIETARY	3,960	3,960	215,477	0	413,011	10.00
11.00	01100	CAFETERIA	2,466	2,466	134,141	0	157,739	11.00
13.00	01300	NURSING ADMINISTRATION	5,138	5,138	1,197,857	0	1,558,256	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,043	1,043	47,186	0	245,331	14.00
15.00	01500	PHARMACY	1,440	1,440	401,382	0	659,198	15.00
17.00	01700	SOCIAL SERVICE	0	0	52,995	0	60,758	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,364	11,364	2,299,148	0	3,065,200	30.00
31.00	03100	INTENSIVE CARE UNIT	3,164	3,164	970,433	0	1,255,329	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,819	14,819	1,592,281	0	1,714,686	50.00
51.00	05100	RECOVERY ROOM	0	0	70,941	0	83,864	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,341	15,341	1,826,449	0	3,100,843	54.00
56.00	05600	RADIOISOTOPE	0	0	87,898	0	188,445	56.00
60.00	06000	LABORATORY	4,708	4,708	275,067	0	3,963,887	60.00
66.00	06600	PHYSICAL THERAPY	4,743	4,743	967,224	0	1,251,105	66.00
69.00	06900	ELECTROCARDIOLOGY	5,293	5,293	784,342	0	1,426,757	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	125,001	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	105,551	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,157,546	73.00
76.97	07697	CARDIAC REHABILITATION	2,236	2,236	50,877	0	96,208	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	524	524	39,449	0	94,798	90.01
91.00	09100	EMERGENCY	5,406	5,406	1,584,345	0	2,711,460	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	135,578	135,578	14,433,941	-12,273,073	32,149,872	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	931	931	10,458	0	25,362	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	47,996	0	0	0	221,599	192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	2,849	2,849	0	0	79,080	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	6,485	0	146,113	0	211,379	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	894,950	1,215,345	2,137,184		12,273,073	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.616976	8.721028	0.146478		0.375469	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			6,803		406,237	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000466		0.012428	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/23/2017 10:55 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	142,467					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	224,212				8.00
9.00	00900	HOUSEKEEPING	2,561	0	85,425			9.00
10.00	01000	DIETARY	3,960	0	3,960	45,951		10.00
11.00	01100	CAFETERIA	2,466	0	2,466	0	167	11.00
13.00	01300	NURSING ADMINISTRATION	5,138	0	5,138	0	13	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,043	0	1,043	0	2	14.00
15.00	01500	PHARMACY	1,440	0	1,440	0	5	15.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	1	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,364	86,981	11,364	37,249	35	30.00
31.00	03100	INTENSIVE CARE UNIT	3,164	43,565	3,164	8,702	11	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,819	53,987	14,819	0	12	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	1	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,341	0	15,341	0	28	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	1	56.00
60.00	06000	LABORATORY	4,708	0	4,708	0	1	60.00
66.00	06600	PHYSICAL THERAPY	4,743	0	4,743	0	13	66.00
69.00	06900	ELECTROCARDIOLOGY	5,293	0	5,293	0	12	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,236	0	2,236	0	1	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	524	0	524	0	1	90.01
91.00	09100	EMERGENCY	5,406	39,679	5,406	0	24	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	84,206	224,212	81,645	45,951	161	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	931	0	931	0	1	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	47,996	0	0	0	0	192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	2,849	0	2,849	0	0	194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	6,485	0	0	0	5	194.02
194.03	07953	HOME CARE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,829,187	1,700	954,230	690,959	293,482	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.858543	0.007582	11.170383	15.036865	1,757.377246	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	298,413	15	47,851	68,564	41,460	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.094611	0.000067	0.560152	1.492111	248.263473	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/23/2017 10:55 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
			13.00	14.00	15.00	17.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
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	83					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	230,552				14.00
15.00	01500	PHARMACY	0	0	100			15.00
17.00	01700	SOCIAL SERVICE	0	0	0	2,883		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35	0	0	2,337		30.00
31.00	03100	INTENSIVE CARE UNIT	11	0	0	546		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12	0	0	0		50.00
51.00	05100	RECOVERY ROOM	1	0	0	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	125,001	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	105,551	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0		90.01
91.00	09100	EMERGENCY	24	0	0	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)	83	230,552	100	2,883		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	MARKETING/PUBLIC RELATIONS	0	0	0	0		194.00
194.02	07952	BLOOMNGTN AMBULANCE AND OCC MED	0	0	0	0		194.02
194.03	07953	HOME CARE	0	0	0	0		194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,325,605	373,323	960,174	85,328		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28,019.337349	1.619257	9,601.740000	29.596948		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	105,322	20,249	32,650	1,028		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1,268.939759	0.087828	326.500000	0.356573		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/23/2017 10:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,240,822		6,240,822	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,299,726		2,299,726	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,176,045		3,176,045	0	0	50.00
51.00	05100	RECOVERY ROOM	145,128		145,128	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,790,336		4,790,336	0	0	54.00
56.00	05600	RADIOISOTOPE	260,957		260,957	0	0	56.00
60.00	06000	LABORATORY	5,600,045		5,600,045	0	0	60.00
66.00	06600	PHYSICAL THERAPY	1,890,872	0	1,890,872	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,147,785		2,147,785	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	374,344		374,344	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	316,096		316,096	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,805,166		10,805,166	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	203,469		203,469	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	CLINIC - DIABETES	148,408		148,408	0	0	90.01
91.00	09100	EMERGENCY	4,612,213		4,612,213	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,185,184		2,185,184		0	92.00
200.00		Subtotal (see instructions)	45,196,596	0	45,196,596	0	0	200.00
201.00		Less Observation Beds	2,185,184		2,185,184		0	201.00
202.00		Total (see instructions)	43,011,412	0	43,011,412	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/23/2017 10:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,640,471		4,640,471			30.00
31.00	03100	INTENSIVE CARE UNIT	4,858,251		4,858,251			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,735,510	17,596,757	19,332,267	0.164287	0.000000	50.00
51.00	05100	RECOVERY ROOM	221,519	2,941,794	3,163,313	0.045878	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	982,863	25,982,797	26,965,660	0.177646	0.000000	54.00
56.00	05600	RADIOISOTOPE	136,436	1,781,283	1,917,719	0.136077	0.000000	56.00
60.00	06000	LABORATORY	3,035,687	18,398,274	21,433,961	0.261270	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	589,634	3,597,242	4,186,876	0.451619	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	1,405,283	9,897,143	11,302,426	0.190029	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	170,220	1,035,044	1,205,264	0.310591	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	65,011	670,962	735,973	0.429494	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,807,618	28,931,776	33,739,394	0.320254	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,070,213	1,070,213	0.190120	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0	51,678	51,678	2.871783	0.000000	90.01
91.00	09100	EMERGENCY	624,791	25,360,282	25,985,073	0.177495	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	78,994	9,345,194	9,424,188	0.231870	0.000000	92.00
200.00		Subtotal (see instructions)	23,352,288	146,660,439	170,012,727			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	23,352,288	146,660,439	170,012,727			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/23/2017 10:55 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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
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 PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	CLINIC - DIABETES	0.000000		90.01
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: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/23/2017 10:55 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	6,240,822		6,240,822	0	6,240,822	30.00
31.00	03100	INTENSIVE CARE UNIT	2,299,726		2,299,726	0	2,299,726	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,176,045		3,176,045	0	3,176,045	50.00
51.00	05100	RECOVERY ROOM	145,128		145,128	0	145,128	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,790,336		4,790,336	0	4,790,336	54.00
56.00	05600	RADIOISOTOPE	260,957		260,957	0	260,957	56.00
60.00	06000	LABORATORY	5,600,045		5,600,045	0	5,600,045	60.00
66.00	06600	PHYSICAL THERAPY	1,890,872	0	1,890,872	0	1,890,872	66.00
69.00	06900	ELECTROCARDIOLOGY	2,147,785		2,147,785	0	2,147,785	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	374,344		374,344	0	374,344	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	316,096		316,096	0	316,096	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,805,166		10,805,166	0	10,805,166	73.00
76.97	07697	CARDIAC REHABILITATION	203,469		203,469	0	203,469	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	CLINIC - DIABETES	148,408		148,408	0	148,408	90.01
91.00	09100	EMERGENCY	4,612,213		4,612,213	0	4,612,213	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,185,184		2,185,184		2,185,184	92.00
200.00		Subtotal (see instructions)	45,196,596	0	45,196,596	0	45,196,596	200.00
201.00		Less Observation Beds	2,185,184		2,185,184		2,185,184	201.00
202.00		Total (see instructions)	43,011,412	0	43,011,412	0	43,011,412	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/23/2017 10:55 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	4,640,471		4,640,471			30.00
31.00	03100	INTENSIVE CARE UNIT	4,858,251		4,858,251			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,735,510	17,596,757	19,332,267	0.164287	0.000000	50.00
51.00	05100	RECOVERY ROOM	221,519	2,941,794	3,163,313	0.045878	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	982,863	25,982,797	26,965,660	0.177646	0.000000	54.00
56.00	05600	RADIOISOTOPE	136,436	1,781,283	1,917,719	0.136077	0.000000	56.00
60.00	06000	LABORATORY	3,035,687	18,398,274	21,433,961	0.261270	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	589,634	3,597,242	4,186,876	0.451619	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	1,405,283	9,897,143	11,302,426	0.190029	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	170,220	1,035,044	1,205,264	0.310591	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	65,011	670,962	735,973	0.429494	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,807,618	28,931,776	33,739,394	0.320254	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,070,213	1,070,213	0.190120	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	CLINIC - DIABETES	0	51,678	51,678	2.871783	0.000000	90.01
91.00	09100	EMERGENCY	624,791	25,360,282	25,985,073	0.177495	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	78,994	9,345,194	9,424,188	0.231870	0.000000	92.00
200.00		Subtotal (see instructions)	23,352,288	146,660,439	170,012,727			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	23,352,288	146,660,439	170,012,727			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/23/2017 10:55 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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
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 PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	CLINIC - DIABETES	0.000000		90.01
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: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/23/2017 10:55 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	277,259	19,332,267	0.014342	851,268	12,209	50.00
51.00	05100	RECOVERY ROOM	2,592	3,163,313	0.000819	107,939	88	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	291,683	26,965,660	0.010817	441,663	4,777	54.00
56.00	05600	RADIOISOTOPE	2,631	1,917,719	0.001372	101,603	139	56.00
60.00	06000	LABORATORY	124,933	21,433,961	0.005829	1,499,212	8,739	60.00
66.00	06600	PHYSICAL THERAPY	95,081	4,186,876	0.022709	244,991	5,564	66.00
69.00	06900	ELECTROCARDIOLOGY	105,727	11,302,426	0.009354	765,327	7,159	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,533	1,205,264	0.010399	80,467	837	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,582	735,973	0.014378	52,787	759	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	121,604	33,739,394	0.003604	2,370,658	8,544	73.00
76.97	07697	CARDIAC REHABILITATION	37,228	1,070,213	0.034786	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	CLINIC - DIABETES	9,825	51,678	0.190120	0	0	90.01
91.00	09100	EMERGENCY	157,308	25,985,073	0.006054	29,403	178	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	115,699	9,424,188	0.012277	5,742	70	92.00
200.00		Total (lines 50-199)	1,364,685	160,514,005		6,551,060	49,063	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/23/2017 10:55 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/23/2017 10:55 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	19,332,267	0.000000	0.000000	851,268	50.00
51.00	05100	RECOVERY ROOM	0	3,163,313	0.000000	0.000000	107,939	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	26,965,660	0.000000	0.000000	441,663	54.00
56.00	05600	RADIOISOTOPE	0	1,917,719	0.000000	0.000000	101,603	56.00
60.00	06000	LABORATORY	0	21,433,961	0.000000	0.000000	1,499,212	60.00
66.00	06600	PHYSICAL THERAPY	0	4,186,876	0.000000	0.000000	244,991	66.00
69.00	06900	ELECTROCARDIOLOGY	0	11,302,426	0.000000	0.000000	765,327	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,205,264	0.000000	0.000000	80,467	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	735,973	0.000000	0.000000	52,787	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	33,739,394	0.000000	0.000000	2,370,658	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,070,213	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	CLINIC - DIABETES	0	51,678	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	25,985,073	0.000000	0.000000	29,403	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	9,424,188	0.000000	0.000000	5,742	92.00
200.00		Total (lines 50-199)	0	160,514,005			6,551,060	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/23/2017 10:55 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
51.00	05100	RECOVERY ROOM	0	0	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	CLINIC - DIABETES	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/23/2017 10:55 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	0.164287	0	5,020,853	0	0	50.00
51.00	05100	RECOVERY ROOM	0.045878	0	786,134	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177646	0	8,708,948	0	0	54.00
56.00	05600	RADIOISOTOPE	0.136077	0	790,946	0	0	56.00
60.00	06000	LABORATORY	0.261270	0	5,458,136	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.451619	0	1,020,009	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.190029	0	3,544,296	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.310591	0	202,973	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.429494	0	224,773	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.320254	0	8,557,346	1,555	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.190120	0	624,448	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.871783	0	9,052	2,952	0	90.01
91.00	09100	EMERGENCY	0.177495	0	8,176,534	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.231870	0	4,798,464	0	0	92.00
200.00		Subtotal (see instructions)		0	47,922,912	4,507	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	47,922,912	4,507	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/23/2017 10:55 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	824,861	0		50.00
51.00	05100	RECOVERY ROOM	36,066	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,547,110	0		54.00
56.00	05600	RADIOISOTOPE	107,630	0		56.00
60.00	06000	LABORATORY	1,426,047	0		60.00
66.00	06600	PHYSICAL THERAPY	460,655	0		66.00
69.00	06900	ELECTROCARDIOLOGY	673,519	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	63,042	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	96,539	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,740,524	498		73.00
76.97	07697	CARDIAC REHABILITATION	118,720	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC - DIABETES	25,995	8,478		90.01
91.00	09100	EMERGENCY	1,451,294	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,112,620	0		92.00
200.00		Subtotal (see instructions)	10,684,622	8,976		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	10,684,622	8,976		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/23/2017 10:55 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	0.164287	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.045878	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177646	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.136077	0	0	0	0	56.00
60.00	06000	LABORATORY	0.261270	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.451619	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.190029	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.310591	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.429494	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.320254	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.190120	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.871783	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.177495	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.231870	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: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V | Date/Time Prepared: 5/23/2017 10:55 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC - DIABETES	0	0		90.01
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: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/23/2017 10:55 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	0.164287	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.045878	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177646	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.136077	0	0	0	0	56.00
60.00	06000	LABORATORY	0.261270	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.451619	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.190029	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.310591	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.429494	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.320254	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.190120	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.871783	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.177495	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.231870	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: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/23/2017 10:55 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	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC - DIABETES	0	0		90.01
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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1328	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/23/2017 10:55 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)	4,458	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,831	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)	2,337	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	416	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	211	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)	1,437	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)	416	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	137.32	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)	6,240,822	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)	28,975	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)	637,433	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,603,389	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)	5,603,389	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)	1,462.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,101,814	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)	2,101,814	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/23/2017 10:55 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,299,726	546	4,211.95	492	2,072,279	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)	1,698,293	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,872,386	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)	608,458	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)	608,458	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)	1,494	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,462.64	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,185,184	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/23/2017 10:55 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	330,435	6,240,822	0.052947	2,185,184	115,699	90.00
91.00	Nursing School cost	0	6,240,822	0.000000	2,185,184	0	91.00
92.00	Allied health cost	0	6,240,822	0.000000	2,185,184	0	92.00
93.00	All other Medical Education	0	6,240,822	0.000000	2,185,184	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1328	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/23/2017 10:55 am
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,458	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,831	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)	2,337	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	416	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	211	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)	33	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	137.32	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)	6,240,822	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)	28,975	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)	637,433	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,603,389	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)	5,603,389	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)	1,462.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	48,267	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)	48,267	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/23/2017 10:55 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,299,726	546	4,211.95	11	46,331	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)	52,051	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	146,649	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,494	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,462.64	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,185,184	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/23/2017 10:55 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	330,435	6,240,822	0.052947	2,185,184	115,699	90.00
91.00	Nursing School cost	0	6,240,822	0.000000	2,185,184	0	91.00
92.00	Allied health cost	0	6,240,822	0.000000	2,185,184	0	92.00
93.00	All other Medical Education	0	6,240,822	0.000000	2,185,184	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/23/2017 10:55 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		2,330,664		30.00
31.00	03100	INTENSIVE CARE UNIT		2,629,969		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.164287	851,268	139,852	50.00
51.00	05100	RECOVERY ROOM	0.045878	107,939	4,952	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177646	441,663	78,460	54.00
56.00	05600	RADIOISOTOPE	0.136077	101,603	13,826	56.00
60.00	06000	LABORATORY	0.261270	1,499,212	391,699	60.00
66.00	06600	PHYSICAL THERAPY	0.451619	244,991	110,643	66.00
69.00	06900	ELECTROCARDIOLOGY	0.190029	765,327	145,434	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.310591	80,467	24,992	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.429494	52,787	22,672	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.320254	2,370,658	759,213	73.00
76.97	07697	CARDIAC REHABILITATION	0.190120	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.871783	0	0	90.01
91.00	09100	EMERGENCY	0.177495	29,403	5,219	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.231870	5,742	1,331	92.00
200.00		Total (sum of lines 50-94 and 96-98)		6,551,060	1,698,293	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)		6,551,060		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/23/2017 10:55 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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.164287	0	0	50.00
51.00	05100	RECOVERY ROOM	0.045878	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177646	14,726	2,616	54.00
56.00	05600	RADIOISOTOPE	0.136077	4,183	569	56.00
60.00	06000	LABORATORY	0.261270	176,741	46,177	60.00
66.00	06600	PHYSICAL THERAPY	0.451619	129,368	58,425	66.00
69.00	06900	ELECTROCARDIOLOGY	0.190029	89,163	16,944	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.310591	3,811	1,184	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.429494	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.320254	365,613	117,089	73.00
76.97	07697	CARDIAC REHABILITATION	0.190120	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.871783	0	0	90.01
91.00	09100	EMERGENCY	0.177495	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.231870	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		783,605	243,004	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)		783,605		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/23/2017 10:55 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		57,186		30.00
31.00	03100	INTENSIVE CARE UNIT		83,887		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.164287	5,985	983	50.00
51.00	05100	RECOVERY ROOM	0.045878	2,783	128	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177646	14,810	2,631	54.00
56.00	05600	RADIOISOTOPE	0.136077	0	0	56.00
60.00	06000	LABORATORY	0.261270	69,773	18,230	60.00
66.00	06600	PHYSICAL THERAPY	0.451619	3,486	1,574	66.00
69.00	06900	ELECTROCARDIOLOGY	0.190029	16,483	3,132	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.310591	101	31	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.429494	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.320254	63,044	20,190	73.00
76.97	07697	CARDIAC REHABILITATION	0.190120	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.871783	0	0	90.01
91.00	09100	EMERGENCY	0.177495	29,026	5,152	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.231870	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		205,491	52,051	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)		205,491		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/23/2017 10:55 am

Title XIX | 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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.164287	0	0	50.00
51.00	05100	RECOVERY ROOM	0.045878	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177646	0	0	54.00
56.00	05600	RADIOISOTOPE	0.136077	0	0	56.00
60.00	06000	LABORATORY	0.261270	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.451619	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.190029	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.310591	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.429494	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.320254	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.190120	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	CLINIC - DIABETES	2.871783	0	0	90.01
91.00	09100	EMERGENCY	0.177495	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.231870	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1328	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/23/2017 10:55 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	10,693,598	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)	10,693,598	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)	10,800,534	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)	82,620	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	8,530,264	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)	2,187,650	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)	2,187,650	30.00
31.00	Primary payer payments	58	31.00
32.00	Subtotal (line 30 minus line 31)	2,187,592	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)	1,337,380	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	869,297	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,321,158	36.00
37.00	Subtotal (see instructions)	3,056,889	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)	3,056,889	40.00
40.01	Sequestration adjustment (see instructions)	61,138	40.01
41.00	Interim payments	2,797,106	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	198,645	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	170,115	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: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I Date/Time Prepared: 5/23/2017 10:55 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		4,342,252		2,560,606	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	07/14/2016	232,200	07/14/2016	236,500	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)		232,200		236,500	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)		4,574,452		2,797,106	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		780,057		198,645	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		5,354,509		2,995,751	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: 15-1328 | Component CCN: 15-Z328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/23/2017 10:55 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		794,886		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	07/14/2016	44,700		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)		44,700		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)		839,586		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		6,291		0	6.02
7.00	Total Medicare program liability (see instructions)		833,295		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: 15-1328	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/23/2017 10:55 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	965	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,929	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	621	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	2,883	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	170,012,727	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	3,000,271	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: 15-1328 Component CCN: 15-Z328	Period: From 01/01/2016 To 12/31/2016	Worksheet E-2 Date/Time Prepared: 5/23/2017 10:55 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)	614,543	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)	245,434	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	416	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)	859,977	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	859,977	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)	859,977	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	10,304	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)	849,673	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	966	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	628	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	966	0	18.00
19.00	Total (see instructions)	850,301	0	19.00
19.01	Sequestration adjustment (see instructions)	17,006	0	19.01
20.00	Interim payments	839,586	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)	-6,291	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	13,586	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1328 Component CCN: 15-Z328	Period: From 01/01/2016 To 12/31/2016	Worksheet E-2 Date/Time Prepared: 5/23/2017 10:55 am
	Title XIX	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)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	0		3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0		16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
20.00	Interim payments	0		20.00
21.00	Tentative settlement (for contractor use only)	0		21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0		22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1328	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part V Date/Time Prepared: 5/23/2017 10:55 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,872,386	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)	5,872,386	4.00
5.00	Primary payer payments	8,992	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,922,118	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)	5,922,118	19.00
20.00	Deductibles (exclude professional component)	503,468	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	5,418,650	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	5,418,650	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	69,439	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	45,135	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	69,439	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,463,785	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)	5,463,785	30.00
30.01	Sequestration adjustment (see instructions)	109,276	30.01
31.00	Interim payments	4,574,452	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)	780,057	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	93,538	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 5/23/2017 10:55 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	29,806,206	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,438,138	0	0	0	4.00
5.00	Other receivable	813,934	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,109,794	0	0	0	7.00
8.00	Prepaid expenses	247,797	0	0	0	8.00
9.00	Other current assets	28,743	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)	39,444,612	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	931,334	0	0	0	12.00
13.00	Land improvements	1,119,735	0	0	0	13.00
14.00	Accumulated depreciation	-937,991	0	0	0	14.00
15.00	Buildings	19,956,874	0	0	0	15.00
16.00	Accumulated depreciation	-11,962,839	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	200,961	0	0	0	21.00
22.00	Accumulated depreciation	-148,320	0	0	0	22.00
23.00	Major movable equipment	20,913,903	0	0	0	23.00
24.00	Accumulated depreciation	-17,594,196	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	567,798	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	13,047,259	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,674,508	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,674,508	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	56,166,379	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,255,531	0	0	0	37.00
38.00	Salaries, wages, and fees payable	380,761	0	0	0	38.00
39.00	Payroll taxes payable	832,464	0	0	0	39.00
40.00	Notes and loans payable (short term)	88,596	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	3,872,699	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,430,051	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	288,155	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	288,155	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	6,718,206	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	49,448,173				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)	49,448,173	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	56,166,379	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 5/23/2017 10:55 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		39,054,745		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		15,039,877				2.00
3.00	Total (sum of line 1 and line 2)		54,094,622		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	INTERCOMPANY CAPITAL TRANSFER	1,317		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)		1,317		0		10.00
11.00	Subtotal (line 3 plus line 10)		54,095,939		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	INTERCOMPANY CAPITAL TRANSFER	4,647,766		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)		4,647,766		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		49,448,173		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	INTERCOMPANY CAPITAL TRANSFER		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	INTERCOMPANY CAPITAL TRANSFER		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: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/23/2017 10:55 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,640,471		4,640,471	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)	4,640,471		4,640,471	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	4,858,251		4,858,251	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)	4,858,251		4,858,251	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	9,498,722		9,498,722	17.00
18.00	Ancillary services	13,774,572	137,315,245	151,089,817	18.00
19.00	Outpatient services	78,994	9,345,194	9,424,188	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	PHYSICIAN REVENUE	0	1,421,946	1,421,946	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	23,352,288	148,082,385	171,434,673	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		44,415,951		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		44,415,951		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1328 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-3 | Date/Time Prepared: 5/23/2017 10:55 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	171,434,673	1.00
2.00	Less contractual allowances and discounts on patients' accounts	113,223,503	2.00
3.00	Net patient revenues (line 1 minus line 2)	58,211,170	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	44,415,951	4.00
5.00	Net income from service to patients (line 3 minus line 4)	13,795,219	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	MISCELLANEOUS INCOME	1,244,658	24.00
25.00	Total other income (sum of lines 6-24)	1,244,658	25.00
26.00	Total (line 5 plus line 25)	15,039,877	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)	15,039,877	29.00