This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet S Parts I-III Date/Time Prepared: 7/28/2016 7:44 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 7/28/2016 Time: 7:44 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH STARKE MEMORIAL HOSPITAL (150102) for the cost reporting period beginning 01/01/2016 and ending 02/29/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

____
Title

____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	4,785	29,096	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	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	4,785	29,096	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: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet S-2 Part I | Date/Time Prepared: 7/28/2016 7:42 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 102 EAST CULVER RD	PO Box:			1.00
2.00	City: KNOX	State: IN	Zip Code: 46534	County: STARKE	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	IU HEALTH STARKE MEMORIAL HOSPITAL	150102	99915	1	07/11/1966	N	P	P	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 STARKE MEMORIAL SWING BED	15U102	99915		09/06/1989	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2016	02/29/2016	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	35	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: 150102	Period: From 01/01/2016 To 02/29/2016	Worksheet S-2 Part I Date/Time Prepared: 7/28/2016 7:42 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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.	1		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.	01/01/2016	02/29/2016	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)	Y	Y	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.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

		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: 150102	Period: From 01/01/2016 To 02/29/2016	Worksheet S-2 Part I Date/Time Prepared: 7/28/2016 7:42 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150102	Period: From 01/01/2016 To 02/29/2016	Worksheet S-2 Part I Date/Time Prepared: 7/28/2016 7:42 pm

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	5,328	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	Y	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	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: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet S-2 Part I Date/Time Prepared: 7/28/2016 7:42 pm

Line	Description	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

Line	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: 08001	141.00
142.00	Street: 340 WEST 10TH STREET	PO Box: N/A		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46202	143.00

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

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

Line	Description	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

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

Line	Description	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

Line	Description	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

Line	Description	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)	0.25	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150102	Period: From 01/01/2016 To 02/29/2016	Worksheet S-2 Part I Date/Time Prepared: 7/28/2016 7:42 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2014	09/30/2015	170.00

		1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)	Y	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 150102	Period: From 01/01/2016 To 02/29/2016	Worksheet S-2 Part II Date/Time Prepared: 7/28/2016 7:42 pm

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

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

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

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

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y	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	05/31/2016	Y	05/31/2016	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 150102	Period: From 01/01/2016 To 02/29/2016	Worksheet S-2 Part II Date/Time Prepared: 7/28/2016 7:42 pm

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

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	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.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA	UTTER	41.00
42.00	Enter the employer/company name of the cost report preparer.	IU 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: 150102	Period: From 01/01/2016 To 02/29/2016	Worksheet S-2 Part II Date/Time Prepared: 7/28/2016 7:42 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGE, REVENUE & REIMBURSEMENT		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: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet S-3 Part I Date/Time Prepared: 7/28/2016 7:42 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	50	3,000	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		50	3,000	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		50	3,000	0.00	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						26.25
27.00	Total (sum of lines 14-26)		50				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: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet S-3 Part I Date/Time Prepared: 7/28/2016 7:42 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	138	0	234			1.00
2.00	HMO and other (see instructions)	29	35				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	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	138	0	234			7.00
8.00	INTENSIVE CARE UNIT	0	0	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)	138	0	234	0.00	113.03	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	113.03	27.00
28.00	Observation Bed Days		31	146			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: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet S-3 Part I Date/Time Prepared: 7/28/2016 7:42 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	44	0	90	1.00
2.00	HMO and other (see instructions)			10	14		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	44	0	90	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						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet S-3 Part II Date/Time Prepared: 7/28/2016 7:42 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	1,155,452	-988	1,154,464	39,184.79	29.46	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		3,333	0	3,333	25.00	133.32	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		4,507	0	4,507	358.40	12.58	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		92,936	0	92,936	539.00	172.42	13.00
14.00	Home office salaries & wage-related costs		77,443	0	77,443	1,356.00	57.11	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		309,535	0	309,535			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		2,780	0	2,780			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		233	0	233			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	134,188	0	134,188	4,959.58	27.06	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	65,100	0	65,100	2,699.49	24.12	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	28,905	-534	28,371	2,000.14	14.18	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	30,477	-22,379	8,098	447.00	18.12	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	22,379	22,379	1,235.00	18.12	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	7,712	0	7,712	298.23	25.86	38.00
39.00	Central Services and Supply	14.00	12,183	0	12,183	642.00	18.98	39.00
40.00	Pharmacy	15.00	33,130	0	33,130	779.73	42.49	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet S-3 Part II | Date/Time Prepared: 7/28/2016 7:42 pm

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

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet S-3 Part III Date/Time Prepared: 7/28/2016 7:42 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		1,155,452	-988	1,154,464	39,184.79	29.46	1.00
2.00	Excluded area salaries (see instructions)		4,507	0	4,507	358.40	12.58	2.00
3.00	Subtotal salaries (line 1 minus line 2)		1,150,945	-988	1,149,957	38,826.39	29.62	3.00
4.00	Subtotal other wages & related costs (see inst.)		170,379	0	170,379	1,895.00	89.91	4.00
5.00	Subtotal wage-related costs (see inst.)		309,768	0	309,768	0.00	26.94	5.00
6.00	Total (sum of lines 3 thru 5)		1,631,092	-988	1,630,104	40,721.39	40.03	6.00
7.00	Total overhead cost (see instructions)		311,695	-534	311,161	13,061.17	23.82	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 150102	Period: From 01/01/2016 To 02/29/2016	Worksheet S-3 Part IV Date/Time Prepared: 7/28/2016 7:42 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	14,978	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	155,281	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	30,047	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	9,207	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	988	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	8,084	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	85,582	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	8,381	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	312,548	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 150102	Period: From 01/01/2016 To 02/29/2016	Worksheet S-3 Part V Date/Time Prepared: 7/28/2016 7:42 pm

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet S-10 | Date/Time Prepared: 7/28/2016 7:42 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.310821	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	447,214	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	3,872,331	6.00
7.00	Medicaid cost (line 1 times line 6)	1,203,602	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)	756,388	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	756,388	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	119,492	89,385	208,877	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	37,141	27,783	64,924	21.00
22.00	Partial payment by patients approved for charity care	629	6,897	7,526	22.00
23.00	Cost of charity care (line 21 minus line 22)	36,512	20,886	57,398	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)	35,612	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	38,050	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	-2,438	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	-758	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	56,640	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	813,028	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet A | Date/Time Prepared: 7/28/2016 7:42 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	25,504	25,504	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	230,183	230,183	0	230,183	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	134,188	580,599	714,787	-25,932	688,855	5.00
7.00	00700	OPERATION OF PLANT	65,100	145,263	210,363	3,937	214,300	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	28,905	18,286	47,191	-554	46,637	9.00
10.00	01000	DIETARY	30,477	23,239	53,716	-39,444	14,272	10.00
11.00	01100	CAFETERIA	0	0	0	39,444	39,444	11.00
13.00	01300	NURSING ADMINISTRATION	7,712	1,692	9,404	0	9,404	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,183	5,496	17,679	88,412	106,091	14.00
15.00	01500	PHARMACY	33,130	144,379	177,509	-131,062	46,447	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	57,520	57,520	0	57,520	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	181,090	34,749	215,839	-9,086	206,753	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	115,879	109,226	225,105	-64,778	160,327	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	52,874	52,874	-615	52,259	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	169,990	242,114	412,104	-14,199	397,905	54.00
57.00	05700	CT SCAN	0	38,706	38,706	0	38,706	57.00
58.00	05800	MRI	13,613	26,810	40,423	0	40,423	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	86,438	142,536	228,974	-3,421	225,553	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	8,930	8,930	0	8,930	62.00
65.00	06500	RESPIRATORY THERAPY	46,422	8,049	54,471	-2,884	51,587	65.00
66.00	06600	PHYSICAL THERAPY	12,587	40,512	53,099	165	53,264	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,919	1,586	22,505	0	22,505	67.00
68.00	06800	SPEECH PATHOLOGY	3,659	269	3,928	0	3,928	68.00
69.00	06900	ELECTROCARDIOLOGY	28,299	7,899	36,198	-278	35,920	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	14,373	14,373	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	979	979	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	146,632	146,632	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
91.00	09100	EMERGENCY	160,354	439,555	599,909	-18,415	581,494	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,150,945	2,360,472	3,511,417	8,778	3,520,195	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	0	38	38	0	38	193.01
193.02	19302	RETAIL PHARMACY	0	8,222	8,222	-7,998	224	193.02
194.00	07950	OTHER NRCC	4,507	14,749	19,256	-780	18,476	194.00
200.00		TOTAL (SUM OF LINES 118-199)	1,155,452	2,383,481	3,538,933	0	3,538,933	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet A | Date/Time Prepared: 7/28/2016 7:42 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	12,336	37,840	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,737	4,737	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-284	229,899	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,203,232	1,892,087	5.00
7.00	00700	OPERATION OF PLANT	0	214,300	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	0	46,637	9.00
10.00	01000	DIETARY	0	14,272	10.00
11.00	01100	CAFETERIA	-12,743	26,701	11.00
13.00	01300	NURSING ADMINISTRATION	-320	9,084	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-1,387	104,704	14.00
15.00	01500	PHARMACY	-544	45,903	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	57,520	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	206,753	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	160,327	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	-52,259	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	397,905	54.00
57.00	05700	CT SCAN	0	38,706	57.00
58.00	05800	MRI	0	40,423	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-1,412	224,141	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	8,930	62.00
65.00	06500	RESPIRATORY THERAPY	-250	51,337	65.00
66.00	06600	PHYSICAL THERAPY	-3,134	50,130	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	22,505	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,928	68.00
69.00	06900	ELECTROCARDIOLOGY	-610	35,310	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	14,373	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	979	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	146,632	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-331,270	250,224	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	816,092	4,336,287	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	190.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	WELLNESS CENTER	0	38	193.01
193.02	19302	RETAIL PHARMACY	0	224	193.02
194.00	07950	OTHER NRCC	-53,837	-35,361	194.00
200.00		TOTAL (SUM OF LINES 118-199)	762,255	4,301,188	200.00

RECLASSIFICATIONS | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet A-6 | Date/Time Prepared: 7/28/2016 7:42 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RENT EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	195	1.00
	TOTALS		0	195	
	B - MEALS				
1.00	CAFETERIA	11.00	22,379	17,065	1.00
	TOTALS		22,379	17,065	
	C - DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	146,632	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
	TOTALS		0	146,632	
	D - SUPPLIES				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	103,764	1.00
2.00	PHYSICAL THERAPY	66.00	0	165	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
	TOTALS		0	103,929	
	E - BILLABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	15,352	1.00
	TOTALS		0	15,352	
	F - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	979	1.00
	TOTALS		0	979	
	H - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	309	1.00
	TOTALS		0	309	
	I - PTO USED AS STD				
1.00	HOUSEKEEPING	9.00	0	534	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	14	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	440	3.00
	TOTALS		0	988	
	J - UTILITY EXPENSE				
1.00	OPERATION OF PLANT	7.00	0	3,958	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	3,958	
	K - PROPERTY TAX				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	25,000	1.00
	TOTALS		0	25,000	
500.00	Grand Total: Increases		22,379	314,407	500.00

RECLASSIFICATIONS | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet A-6 | Date/Time Prepared: 7/28/2016 7:42 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - RENT EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	195	10	1.00
	TOTALS		0	195		
	B - MEALS					
1.00	DIETARY	10.00	22,379	17,065	0	1.00
	TOTALS		22,379	17,065		
	C - DRUGS					
1.00	PHARMACY	15.00	0	131,053	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	280	0	2.00
3.00	OPERATING ROOM	50.00	0	686	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,458	0	4.00
5.00	LABORATORY	60.00	0	92	0	5.00
6.00	RESPIRATORY THERAPY	65.00	0	10	0	6.00
7.00	EMERGENCY	91.00	0	55	0	7.00
8.00	RETAIL PHARMACY	193.02	0	7,998	0	8.00
	TOTALS		0	146,632		
	D - SUPPLIES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	428	0	1.00
2.00	OPERATION OF PLANT	7.00	0	21	0	2.00
3.00	HOUSEKEEPING	9.00	0	554	0	3.00
4.00	PHARMACY	15.00	0	9	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	8,806	0	5.00
6.00	OPERATING ROOM	50.00	0	64,092	0	6.00
7.00	ANESTHESIOLOGY	53.00	0	615	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,563	0	8.00
9.00	LABORATORY	60.00	0	3,329	0	9.00
10.00	RESPIRATORY THERAPY	65.00	0	2,874	0	10.00
11.00	ELECTROCARDIOLOGY	69.00	0	278	0	11.00
12.00	EMERGENCY	91.00	0	18,360	0	12.00
	TOTALS		0	103,929		
	E - BILLABLE SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	15,352	0	1.00
	TOTALS		0	15,352		
	F - IMPLANTABLE DEVICES					
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	979	0	1.00
	TOTALS		0	979		
	H - INTEREST EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	309	11	1.00
	TOTALS		0	309		
	I - PTO USED AS STD					
1.00	HOUSEKEEPING	9.00	534	0	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	14	0	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	440	0	0	3.00
	TOTALS		988	0		
	J - UTILITY EXPENSE					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,178	0	1.00
2.00	OTHER NRCC	194.00	0	780	0	2.00
	TOTALS		0	3,958		
	K - PROPERTY TAX					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	25,000	13	1.00
	TOTALS		0	25,000		
500.00	Grand Total: Decreases		23,367	313,419		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet A-7 Part I | Date/Time Prepared: 7/28/2016 7:42 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	142,789	0	0	0	0	1.00
2.00	Land Improvements	37,448	0	0	0	0	2.00
3.00	Buildings and Fixtures	1,509,571	0	0	0	0	3.00
4.00	Building Improvements	5,139,815	4,517	0	4,517	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	9,752,977	16,532	0	16,532	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,582,600	21,049	0	21,049	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	16,582,600	21,049	0	21,049	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	142,789	0	1.00
2.00	Land Improvements	37,448	0	2.00
3.00	Buildings and Fixtures	1,509,571	0	3.00
4.00	Building Improvements	5,144,332	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	9,769,509	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,603,649	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	16,603,649	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet A-7 Part II | Date/Time Prepared: 7/28/2016 7:42 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	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	CAP REL COSTS-BLDG & FIXT	0	0	1.00
2.00	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: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet A-7 Part III Date/Time Prepared: 7/28/2016 7:42 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	6,834,140	0	6,834,140	0.411605	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,769,509	0	9,769,509	0.588395	0	2.00
3.00	Total (sum of lines 1-2)	16,603,649	0	16,603,649	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	12,645	195	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,737	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	17,382	195	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	25,000	0	37,840	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,737	2.00
3.00	Total (sum of lines 1-2)	0	0	25,000	0	42,577	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet A-8 | Date/Time Prepared: 7/28/2016 7:42 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-309	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-390,730			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	1,306,720			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-12,743	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-1,387	CENTRAL SERVICES & SUPPLY	14.00	0	16.00
17.00	Sale of drugs to other than patients	B	-544	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MEDICAID ASSESSMENT FEE - 2015	A	-60,871	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	EXCESS STARKE BENEFITS	A	-4,514	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet A-8 | Date/Time Prepared: 7/28/2016 7:42 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	ADVERTISING	A	-8,307	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-459	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-320	NURSING ADMINISTRATION	13.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-3,134	PHYSICAL THERAPY	66.00	0	33.05
33.06	TELEPHONE EXPENSE	A	-1,219	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PATIENT REGISTRATION - PHONES	A	-6,091	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	I/C MISCELLANEOUS REVENUE	B	-53,837	OTHER NRCC	194.00	0	33.08
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		762,255				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: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet A-8-1 | Date/Time Prepared: 7/28/2016 7:42 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE CAPITAL BLDG	12,645	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE CAPITAL MME	4,737	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ADMIN	1,421,347	136,239	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	INTERCOMPANY EXPENSE BENEFIT	4,230	0	4.00
4.02	15.00	PHARMACY	INTERCOMPANY PURCHASED SERVI	9,060	9,060	4.02
4.03	16.00	MEDICAL RECORDS & LIBRARY	INTERCOMPANY PURCHASED SERVI	57,520	57,520	4.03
4.04	60.00	LABORATORY	INTERCOMPANY PURCHASED SERVI	43,983	43,983	4.04
4.05	66.00	PHYSICAL THERAPY	INTERCOMPANY PURCHASED SERVI	130	130	4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,553,652	246,932	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.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		0.00	IU HEALTH INC	100.00	6.00
7.00	B		0.00	LAPORTE REGIONA	100.00	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: 150102	Period: From 01/01/2016 To 02/29/2016	Worksheet A-8-1 Date/Time Prepared: 7/28/2016 7:42 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	12,645	9	1.00
2.00	4,737	9	2.00
3.00	1,285,108	0	3.00
4.00	4,230	0	4.00
4.02	0	0	4.02
4.03	0	0	4.03
4.04	0	0	4.04
4.05	0	0	4.05
5.00	1,306,720		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.

	Type of Business	
6.00	HEALTH SYSTEM	6.00
7.00	HEALTH SYSTEM	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: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet A-8-2 | Date/Time Prepared: 7/28/2016 7:42 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	5,083	4,833	250	159,800	2	1.00
2.00	53.00	ANESTHESIOLOGY	52,259	52,259	0	167,500	0	2.00
3.00	60.00	LABORATORY	3,333	0	3,333	159,800	25	3.00
4.00	65.00	RESPIRATORY THERAPY	250	250	0	159,800	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	610	610	0	159,800	0	5.00
6.00	91.00	EMERGENCY	372,526	279,840	92,686	159,800	537	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			434,061	337,792	96,269		564	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	154	8	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	1,921	96	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	41,256	2,063	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			43,331	2,167	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	154	96	4,929	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	52,259	2.00
3.00	60.00	LABORATORY	0	1,921	1,412	1,412	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	250	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	610	5.00
6.00	91.00	EMERGENCY	0	41,256	51,430	331,270	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	43,331	52,938	390,730	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet B Part I Date/Time Prepared: 7/28/2016 7:42 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	37,840	37,840				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,737		4,737			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	229,899	122	15	230,036		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,892,087	3,937	493	26,738	1,923,255	5.00
7.00	00700	OPERATION OF PLANT	214,300	12,167	1,527	12,972	240,966	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	154	19	0	173	8.00
9.00	00900	HOUSEKEEPING	46,637	147	18	5,653	52,455	9.00
10.00	01000	DIETARY	14,272	275	34	1,614	16,195	10.00
11.00	01100	CAFETERIA	26,701	761	95	4,459	32,016	11.00
13.00	01300	NURSING ADMINISTRATION	9,084	33	4	1,537	10,658	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	104,704	602	75	2,428	107,809	14.00
15.00	01500	PHARMACY	45,903	238	30	6,601	52,772	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	57,520	512	64	0	58,096	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	206,753	3,934	492	36,081	247,260	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	160,327	2,908	364	23,090	186,689	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	397,905	1,877	235	33,784	433,801	54.00
57.00	05700	CT SCAN	38,706	165	21	0	38,892	57.00
58.00	05800	MRI	40,423	154	19	2,712	43,308	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	224,141	865	108	17,223	242,337	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	8,930	0	0	0	8,930	62.00
65.00	06500	RESPIRATORY THERAPY	51,337	969	121	9,250	61,677	65.00
66.00	06600	PHYSICAL THERAPY	50,130	689	86	2,508	53,413	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,505	99	12	4,168	26,784	67.00
68.00	06800	SPEECH PATHOLOGY	3,928	99	12	729	4,768	68.00
69.00	06900	ELECTROCARDIOLOGY	35,310	191	24	5,639	41,164	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	14,373	0	0	0	14,373	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	979	0	0	0	979	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	146,632	0	0	0	146,632	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
91.00	09100	EMERGENCY	250,224	1,205	151	31,952	283,532	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,336,287	32,103	4,019	229,138	4,328,934	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	96	12	0	108	190.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	38	0	0	0	38	193.01
193.02	19302	RETAIL PHARMACY	224	0	0	0	224	193.02
194.00	07950	OTHER NRCC	-35,361	5,641	706	898	-28,116	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,301,188	37,840	4,737	230,036	4,301,188	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet B Part I Date/Time Prepared: 7/28/2016 7:42 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,923,255					5.00
7.00	00700	OPERATION OF PLANT	192,614	433,580				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	138	3,092	3,403			8.00
9.00	00900	HOUSEKEEPING	41,929	2,949	0	97,333		9.00
10.00	01000	DIETARY	12,945	5,521	0	1,698	36,359	10.00
11.00	01100	CAFETERIA	25,592	15,264	0	4,696	0	11.00
13.00	01300	NURSING ADMINISTRATION	8,519	654	0	201	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	86,176	12,082	0	3,717	0	14.00
15.00	01500	PHARMACY	42,183	4,777	0	1,470	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	46,439	10,280	0	3,163	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	197,645	78,909	3,403	24,276	36,359	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	149,228	58,339	0	17,947	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	346,757	37,644	0	11,580	0	54.00
57.00	05700	CT SCAN	31,088	3,307	0	1,017	0	57.00
58.00	05800	MRI	34,618	3,083	0	948	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	193,710	17,352	0	5,338	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	7,138	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	49,301	19,441	0	5,980	0	65.00
66.00	06600	PHYSICAL THERAPY	42,695	13,821	0	4,252	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,410	1,990	0	612	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,811	1,990	0	612	0	68.00
69.00	06900	ELECTROCARDIOLOGY	32,904	3,836	0	1,180	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	11,489	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	783	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	117,209	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
91.00	09100	EMERGENCY	226,639	24,164	0	7,433	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,922,960	318,495	3,403	96,120	36,359	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	86	1,918	0	590	0	190.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	30	0	0	0	0	193.01
193.02	19302	RETAIL PHARMACY	179	0	0	0	0	193.02
194.00	07950	OTHER NRCC	0	113,167	0	623	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,923,255	433,580	3,403	97,333	36,359	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet B Part I Date/Time Prepared: 7/28/2016 7:42 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	77,568					11.00
13.00	01300	NURSING ADMINISTRATION	831	20,863				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,787	0	211,571			14.00
15.00	01500	PHARMACY	2,173	0	19	103,394		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	117,978	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,007	9,869	18,101	0	8,507	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,812	3,998	100,188	0	11,261	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	1,264	0	2,963	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,974	0	9,380	0	14,517	54.00
57.00	05700	CT SCAN	0	0	0	0	14,193	57.00
58.00	05800	MRI	888	0	0	0	3,835	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	8,344	0	6,843	0	20,335	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	177	62.00
65.00	06500	RESPIRATORY THERAPY	4,230	0	5,908	0	1,904	65.00
66.00	06600	PHYSICAL THERAPY	1,787	0	0	0	2,314	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,381	0	0	0	807	67.00
68.00	06800	SPEECH PATHOLOGY	328	0	0	0	309	68.00
69.00	06900	ELECTROCARDIOLOGY	2,105	0	571	0	4,136	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	29,545	0	937	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,012	0	444	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	103,394	12,133	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
91.00	09100	EMERGENCY	13,926	6,996	37,740	0	19,206	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	76,573	20,863	211,571	103,394	117,978	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	29	0	0	0	0	193.01
193.02	19302	RETAIL PHARMACY	0	0	0	0	0	193.02
194.00	07950	OTHER NRCC	966	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	77,568	20,863	211,571	103,394	117,978	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet B Part I Date/Time Prepared: 7/28/2016 7:42 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	639,336	0	639,336		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	537,462	0	537,462		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	4,227	0	4,227		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	867,653	0	867,653		54.00
57.00	05700	CT SCAN	88,497	0	88,497		57.00
58.00	05800	MRI	86,680	0	86,680		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	494,259	0	494,259		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	16,245	0	16,245		62.00
65.00	06500	RESPIRATORY THERAPY	148,441	0	148,441		65.00
66.00	06600	PHYSICAL THERAPY	118,282	0	118,282		66.00
67.00	06700	OCCUPATIONAL THERAPY	52,984	0	52,984		67.00
68.00	06800	SPEECH PATHOLOGY	11,818	0	11,818		68.00
69.00	06900	ELECTROCARDIOLOGY	85,896	0	85,896		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	56,344	0	56,344		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,218	0	4,218		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	379,368	0	379,368		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
91.00	09100	EMERGENCY	619,636	0	619,636		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0			92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,211,346	0	4,211,346		118.00
	NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	2,702	0	2,702		190.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	WELLNESS CENTER	97	0	97		193.01
193.02	19302	RETAIL PHARMACY	403	0	403		193.02
194.00	07950	OTHER NRCC	86,640	0	86,640		194.00
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)	4,301,188	0	4,301,188		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet B Part II Date/Time Prepared: 7/28/2016 7:42 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	122	15	137	137	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	122,405	3,937	493	126,835	16	5.00
7.00	00700	OPERATION OF PLANT	15,822	12,167	1,527	29,516	8	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	154	19	173	0	8.00
9.00	00900	HOUSEKEEPING	154	147	18	319	3	9.00
10.00	01000	DIETARY	379	275	34	688	1	10.00
11.00	01100	CAFETERIA	0	761	95	856	3	11.00
13.00	01300	NURSING ADMINISTRATION	1,150	33	4	1,187	1	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	602	75	677	1	14.00
15.00	01500	PHARMACY	367	238	30	635	4	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	512	64	576	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,709	3,934	492	10,135	22	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,720	2,908	364	23,992	14	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,779	1,877	235	59,891	20	54.00
57.00	05700	CT SCAN	28,560	165	21	28,746	0	57.00
58.00	05800	MRI	5,601	154	19	5,774	2	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	3,448	865	108	4,421	10	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	651	969	121	1,741	6	65.00
66.00	06600	PHYSICAL THERAPY	4,398	689	86	5,173	1	66.00
67.00	06700	OCCUPATIONAL THERAPY	66	99	12	177	2	67.00
68.00	06800	SPEECH PATHOLOGY	0	99	12	111	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,935	191	24	3,150	3	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
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
91.00	09100	EMERGENCY	9,119	1,205	151	10,475	19	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	279,263	32,103	4,019	315,385	136	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	96	12	108	0	190.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	0	0	0	0	0	193.01
193.02	19302	RETAIL PHARMACY	0	0	0	0	0	193.02
194.00	07950	OTHER NRCC	10,318	5,641	706	16,665	1	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	289,581	37,840	4,737	332,158	137	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet B Part II | Date/Time Prepared: 7/28/2016 7:42 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	126,851					5.00
7.00	00700	OPERATION OF PLANT	12,704	42,228				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9	301	483			8.00
9.00	00900	HOUSEKEEPING	2,766	287	0	3,375		9.00
10.00	01000	DIETARY	854	538	0	59	2,140	10.00
11.00	01100	CAFETERIA	1,688	1,487	0	163	0	11.00
13.00	01300	NURSING ADMINISTRATION	562	64	0	7	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,684	1,177	0	129	0	14.00
15.00	01500	PHARMACY	2,782	465	0	51	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,063	1,001	0	110	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,036	7,685	483	842	2,140	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,843	5,682	0	622	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,870	3,666	0	402	0	54.00
57.00	05700	CT SCAN	2,050	322	0	35	0	57.00
58.00	05800	MRI	2,283	300	0	33	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	12,776	1,690	0	185	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	471	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	3,252	1,893	0	207	0	65.00
66.00	06600	PHYSICAL THERAPY	2,816	1,346	0	147	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,412	194	0	21	0	67.00
68.00	06800	SPEECH PATHOLOGY	251	194	0	21	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,170	374	0	41	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	758	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,731	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
91.00	09100	EMERGENCY	14,948	2,353	0	258	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	126,831	31,019	483	3,333	2,140	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	6	187	0	20	0	190.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	2	0	0	0	0	193.01
193.02	19302	RETAIL PHARMACY	12	0	0	0	0	193.02
194.00	07950	OTHER NRCC	0	11,022	0	22	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	126,851	42,228	483	3,375	2,140	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet B Part II | Date/Time Prepared: 7/28/2016 7:42 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	4,197					11.00
13.00	01300	NURSING ADMINISTRATION	45	1,866				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	97	0	7,765			14.00
15.00	01500	PHARMACY	118	0	1	4,056		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	4,750	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	811	882	664	0	343	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	531	358	3,678	0	454	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	46	0	119	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	756	0	344	0	585	54.00
57.00	05700	CT SCAN	0	0	0	0	572	57.00
58.00	05800	MRI	48	0	0	0	155	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	451	0	251	0	814	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	7	62.00
65.00	06500	RESPIRATORY THERAPY	229	0	217	0	77	65.00
66.00	06600	PHYSICAL THERAPY	97	0	0	0	93	66.00
67.00	06700	OCCUPATIONAL THERAPY	75	0	0	0	33	67.00
68.00	06800	SPEECH PATHOLOGY	18	0	0	0	12	68.00
69.00	06900	ELECTROCARDIOLOGY	114	0	21	0	167	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	1,084	0	38	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	74	0	18	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,056	489	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
91.00	09100	EMERGENCY	753	626	1,385	0	774	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,143	1,866	7,765	4,056	4,750	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	2	0	0	0	0	193.01
193.02	19302	RETAIL PHARMACY	0	0	0	0	0	193.02
194.00	07950	OTHER NRCC	52	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,197	1,866	7,765	4,056	4,750	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet B Part II | Date/Time Prepared: 7/28/2016 7:42 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	37,043	0	37,043	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	45,174	0	45,174	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	165	0	165	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	88,534	0	88,534	54.00
57.00	05700	CT SCAN	31,725	0	31,725	57.00
58.00	05800	MRI	8,595	0	8,595	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	20,598	0	20,598	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	478	0	478	62.00
65.00	06500	RESPIRATORY THERAPY	7,622	0	7,622	65.00
66.00	06600	PHYSICAL THERAPY	9,673	0	9,673	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,914	0	1,914	67.00
68.00	06800	SPEECH PATHOLOGY	607	0	607	68.00
69.00	06900	ELECTROCARDIOLOGY	6,040	0	6,040	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,880	0	1,880	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	144	0	144	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,276	0	12,276	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
91.00	09100	EMERGENCY	31,591	0	31,591	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0		92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	304,059	0	304,059	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	321	0	321	190.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
193.01	19301	WELLNESS CENTER	4	0	4	193.01
193.02	19302	RETAIL PHARMACY	12	0	12	193.02
194.00	07950	OTHER NRCC	27,762	0	27,762	194.00
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)	332,158	0	332,158	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet B-1 | Date/Time Prepared: 7/28/2016 7:42 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	84,693					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		84,693				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	274	274	1,154,464			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,812	8,812	134,188	-1,923,255	2,406,049	5.00
7.00	00700	OPERATION OF PLANT	27,232	27,232	65,100	0	240,966	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	345	345	0	0	173	8.00
9.00	00900	HOUSEKEEPING	329	329	28,371	0	52,455	9.00
10.00	01000	DIETARY	616	616	8,098	0	16,195	10.00
11.00	01100	CAFETERIA	1,703	1,703	22,379	0	32,016	11.00
13.00	01300	NURSING ADMINISTRATION	73	73	7,712	0	10,658	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,348	1,348	12,183	0	107,809	14.00
15.00	01500	PHARMACY	533	533	33,130	0	52,772	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,147	1,147	0	0	58,096	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,804	8,804	181,076	0	247,260	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,509	6,509	115,879	0	186,689	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,200	4,200	169,550	0	433,801	54.00
57.00	05700	CT SCAN	369	369	0	0	38,892	57.00
58.00	05800	MRI	344	344	13,613	0	43,308	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,936	1,936	86,438	0	242,337	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	8,930	62.00
65.00	06500	RESPIRATORY THERAPY	2,169	2,169	46,422	0	61,677	65.00
66.00	06600	PHYSICAL THERAPY	1,542	1,542	12,587	0	53,413	66.00
67.00	06700	OCCUPATIONAL THERAPY	222	222	20,919	0	26,784	67.00
68.00	06800	SPEECH PATHOLOGY	222	222	3,659	0	4,768	68.00
69.00	06900	ELECTROCARDIOLOGY	428	428	28,299	0	41,164	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	14,373	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	979	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	146,632	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
91.00	09100	EMERGENCY	2,696	2,696	160,354	0	283,532	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	71,853	71,853	1,149,957	-1,923,255	2,405,679	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	214	214	0	0	108	190.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	0	0	0	0	38	193.01
193.02	19302	RETAIL PHARMACY	0	0	0	0	224	193.02
194.00	07950	OTHER NRCC	12,626	12,626	4,507	28,116	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	37,840	4,737	230,036		1,923,255	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.446790	0.055931	0.199258		0.799342	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			137		126,851	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000119		0.052722	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet B-1 | Date/Time Prepared: 7/28/2016 7:42 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (FTE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	48,375					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	345	234				8.00
9.00	00900	HOUSEKEEPING	329	0	35,301			9.00
10.00	01000	DIETARY	616	0	616	234		10.00
11.00	01100	CAFETERIA	1,703	0	1,703	0	8,032	11.00
13.00	01300	NURSING ADMINISTRATION	73	0	73	0	86	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,348	0	1,348	0	185	14.00
15.00	01500	PHARMACY	533	0	533	0	225	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,147	0	1,147	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,804	234	8,804	234	1,554	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,509	0	6,509	0	1,016	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,200	0	4,200	0	1,447	54.00
57.00	05700	CT SCAN	369	0	369	0	0	57.00
58.00	05800	MRI	344	0	344	0	92	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,936	0	1,936	0	864	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,169	0	2,169	0	438	65.00
66.00	06600	PHYSICAL THERAPY	1,542	0	1,542	0	185	66.00
67.00	06700	OCCUPATIONAL THERAPY	222	0	222	0	143	67.00
68.00	06800	SPEECH PATHOLOGY	222	0	222	0	34	68.00
69.00	06900	ELECTROCARDIOLOGY	428	0	428	0	218	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
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
91.00	09100	EMERGENCY	2,696	0	2,696	0	1,442	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	35,535	234	34,861	234	7,929	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	214	0	214	0	0	190.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	0	0	0	0	3	193.01
193.02	19302	RETAIL PHARMACY	0	0	0	0	0	193.02
194.00	07950	OTHER NRCC	12,626	0	226	0	100	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	433,580	3,403	97,333	36,359	77,568	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.962894	14.542735	2.757231	155.380342	9.657371	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	42,228	483	3,375	2,140	4,197	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.872930	2.064103	0.095606	9.145299	0.522535	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet B-1 | Date/Time Prepared: 7/28/2016 7:42 pm

		Cost Center Description	NURSING ADMINISTRATION (TOTAL NURSING SALAR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	341,003					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	102,926				14.00
15.00	01500	PHARMACY	0	9	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	13,549,102		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	161,311	8,806	0	977,017		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	65,343	48,740	0	1,293,368		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	615	0	340,348		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,563	0	1,667,277		54.00
57.00	05700	CT SCAN	0	0	0	1,630,023		57.00
58.00	05800	MRI	0	0	0	440,406		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	3,329	0	2,334,818		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	20,352		62.00
65.00	06500	RESPIRATORY THERAPY	0	2,874	0	218,652		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	265,812		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	92,732		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	35,497		68.00
69.00	06900	ELECTROCARDIOLOGY	0	278	0	474,992		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	14,373	0	107,597		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	979	0	50,956		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	1,393,493		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
91.00	09100	EMERGENCY	114,349	18,360	0	2,205,762		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	341,003	102,926	100	13,549,102		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0		190.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	WELLNESS CENTER	0	0	0	0		193.01
193.02	19302	RETAIL PHARMACY	0	0	0	0		193.02
194.00	07950	OTHER NRCC	0	0	0	0		194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	20,863	211,571	103,394	117,978		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.061181	2.055564	1,033.940000	0.008707		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,866	7,765	4,056	4,750		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.005472	0.075443	40.560000	0.000351		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet C Part I Date/Time Prepared: 7/28/2016 7:42 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
					Costs			
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	639,336		639,336	0	639,336	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	537,462		537,462	0	537,462	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	4,227		4,227	0	4,227	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	867,653		867,653	0	867,653	54.00
57.00	05700	CT SCAN	88,497		88,497	0	88,497	57.00
58.00	05800	MRI	86,680		86,680	0	86,680	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	494,259		494,259	1,412	495,671	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	16,245		16,245	0	16,245	62.00
65.00	06500	RESPIRATORY THERAPY	148,441	0	148,441	0	148,441	65.00
66.00	06600	PHYSICAL THERAPY	118,282	0	118,282	0	118,282	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,984	0	52,984	0	52,984	67.00
68.00	06800	SPEECH PATHOLOGY	11,818	0	11,818	0	11,818	68.00
69.00	06900	ELECTROCARDIOLOGY	85,896		85,896	0	85,896	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	56,344		56,344	0	56,344	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,218		4,218	0	4,218	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	379,368		379,368	0	379,368	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
91.00	09100	EMERGENCY	619,636		619,636	51,430	671,066	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	245,639		245,639		245,639	92.00
200.00		Subtotal (see instructions)	4,456,985	0	4,456,985	52,842	4,509,827	200.00
201.00		Less Observation Beds	245,639		245,639		245,639	201.00
202.00		Total (see instructions)	4,211,346	0	4,211,346	52,842	4,264,188	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet C Part I | Date/Time Prepared: 7/28/2016 7:42 pm

Title XVIII | Hospital | PPS

		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	573,015		573,015			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	74,427	1,218,941	1,293,368	0.415552	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	13,396	326,952	340,348	0.012420	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,791	1,594,486	1,667,277	0.520401	0.000000	54.00
57.00	05700	CT SCAN	132,431	1,497,592	1,630,023	0.054292	0.000000	57.00
58.00	05800	MRI	18,422	421,984	440,406	0.196818	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	333,587	2,001,231	2,334,818	0.211691	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	8,982	11,370	20,352	0.798202	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	139,737	78,915	218,652	0.678892	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	9,427	256,385	265,812	0.444984	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,359	82,373	92,732	0.571367	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	5,195	30,302	35,497	0.332930	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	69,163	405,829	474,992	0.180837	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	46,095	61,502	107,597	0.523658	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	50,956	50,956	0.082777	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	407,184	986,309	1,393,493	0.272242	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	214,379	1,991,383	2,205,762	0.280917	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	27,020	376,982	404,002	0.608014	0.000000	92.00
200.00		Subtotal (see instructions)	2,155,610	11,393,492	13,549,102			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,155,610	11,393,492	13,549,102			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet C Part I | Date/Time Prepared: 7/28/2016 7:42 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.415552	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.012420	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.520401	54.00
57.00	05700	CT SCAN	0.054292	57.00
58.00	05800	MRI	0.196818	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.212295	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.798202	62.00
65.00	06500	RESPIRATORY THERAPY	0.678892	65.00
66.00	06600	PHYSICAL THERAPY	0.444984	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.571367	67.00
68.00	06800	SPEECH PATHOLOGY	0.332930	68.00
69.00	06900	ELECTROCARDIOLOGY	0.180837	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.523658	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.082777	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272242	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.304233	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.608014	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: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet C Part I Date/Time Prepared: 7/28/2016 7:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	639,336		639,336	0	639,336	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	537,462		537,462	0	537,462	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	4,227		4,227	0	4,227	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	867,653		867,653	0	867,653	54.00
57.00	05700	CT SCAN	88,497		88,497	0	88,497	57.00
58.00	05800	MRI	86,680		86,680	0	86,680	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	494,259		494,259	1,412	495,671	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	16,245		16,245	0	16,245	62.00
65.00	06500	RESPIRATORY THERAPY	148,441	0	148,441	0	148,441	65.00
66.00	06600	PHYSICAL THERAPY	118,282	0	118,282	0	118,282	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,984	0	52,984	0	52,984	67.00
68.00	06800	SPEECH PATHOLOGY	11,818	0	11,818	0	11,818	68.00
69.00	06900	ELECTROCARDIOLOGY	85,896		85,896	0	85,896	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	56,344		56,344	0	56,344	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,218		4,218	0	4,218	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	379,368		379,368	0	379,368	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
91.00	09100	EMERGENCY	619,636		619,636	51,430	671,066	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	245,639		245,639		245,639	92.00
200.00		Subtotal (see instructions)	4,456,985	0	4,456,985	52,842	4,509,827	200.00
201.00		Less Observation Beds	245,639		245,639		245,639	201.00
202.00		Total (see instructions)	4,211,346	0	4,211,346	52,842	4,264,188	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet C Part I | Date/Time Prepared: 7/28/2016 7:42 pm

Title XIX | Hospital | PPS

		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	573,015		573,015			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	74,427	1,218,941	1,293,368	0.415552	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	13,396	326,952	340,348	0.012420	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,791	1,594,486	1,667,277	0.520401	0.000000	54.00
57.00	05700	CT SCAN	132,431	1,497,592	1,630,023	0.054292	0.000000	57.00
58.00	05800	MRI	18,422	421,984	440,406	0.196818	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	333,587	2,001,231	2,334,818	0.211691	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	8,982	11,370	20,352	0.798202	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	139,737	78,915	218,652	0.678892	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	9,427	256,385	265,812	0.444984	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,359	82,373	92,732	0.571367	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	5,195	30,302	35,497	0.332930	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	69,163	405,829	474,992	0.180837	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	46,095	61,502	107,597	0.523658	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	50,956	50,956	0.082777	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	407,184	986,309	1,393,493	0.272242	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	214,379	1,991,383	2,205,762	0.280917	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	27,020	376,982	404,002	0.608014	0.000000	92.00
200.00		Subtotal (see instructions)	2,155,610	11,393,492	13,549,102			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,155,610	11,393,492	13,549,102			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet C Part I | Date/Time Prepared: 7/28/2016 7:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.415552	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.012420	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.520401	54.00
57.00	05700	CT SCAN	0.054292	57.00
58.00	05800	MRI	0.196818	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.212295	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.798202	62.00
65.00	06500	RESPIRATORY THERAPY	0.678892	65.00
66.00	06600	PHYSICAL THERAPY	0.444984	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.571367	67.00
68.00	06800	SPEECH PATHOLOGY	0.332930	68.00
69.00	06900	ELECTROCARDIOLOGY	0.180837	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.523658	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.082777	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272242	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.304233	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.608014	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet C Part II | Date/Time Prepared: 7/28/2016 7:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	537,462	45,174	492,288	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	4,227	165	4,062	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	867,653	88,534	779,119	0	0	54.00
57.00	05700	CT SCAN	88,497	31,725	56,772	0	0	57.00
58.00	05800	MRI	86,680	8,595	78,085	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	494,259	20,598	473,661	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	16,245	478	15,767	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	148,441	7,622	140,819	0	0	65.00
66.00	06600	PHYSICAL THERAPY	118,282	9,673	108,609	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,984	1,914	51,070	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,818	607	11,211	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	85,896	6,040	79,856	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	56,344	1,880	54,464	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,218	144	4,074	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	379,368	12,276	367,092	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
91.00	09100	EMERGENCY	619,636	31,591	588,045	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	245,639	14,232	231,407	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	3,817,649	281,248	3,536,401	0	0	200.00
201.00		Less Observation Beds	245,639	14,232	231,407	0	0	201.00
202.00		Total (line 200 minus line 201)	3,572,010	267,016	3,304,994	0	0	202.00

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

Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet C Part II | Date/Time Prepared: 7/28/2016 7:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	537,462	1,293,368	0.415552	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	4,227	340,348	0.012420	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	867,653	1,667,277	0.520401	54.00
57.00	05700	CT SCAN	88,497	1,630,023	0.054292	57.00
58.00	05800	MRI	86,680	440,406	0.196818	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	59.00
60.00	06000	LABORATORY	494,259	2,334,818	0.211691	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	16,245	20,352	0.798202	62.00
65.00	06500	RESPIRATORY THERAPY	148,441	218,652	0.678892	65.00
66.00	06600	PHYSICAL THERAPY	118,282	265,812	0.444984	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,984	92,732	0.571367	67.00
68.00	06800	SPEECH PATHOLOGY	11,818	35,497	0.332930	68.00
69.00	06900	ELECTROCARDIOLOGY	85,896	474,992	0.180837	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	56,344	107,597	0.523658	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,218	50,956	0.082777	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	379,368	1,393,493	0.272242	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0	0.000000	90.00
91.00	09100	EMERGENCY	619,636	2,205,762	0.280917	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	245,639	404,002	0.608014	92.00
200.00		Subtotal (sum of lines 50 thru 199)	3,817,649	12,976,087		200.00
201.00		Less Observation Beds	245,639	0		201.00
202.00		Total (line 200 minus line 201)	3,572,010	12,976,087		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet D Part I Date/Time Prepared: 7/28/2016 7:42 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	37,043	0	37,043	380	97.48	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
200.00	Total (lines 30-199)	37,043		37,043	380		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	138	13,452	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
200.00	Total (lines 30-199)	138	13,452	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 150102	Period: From 01/01/2016 To 02/29/2016	Worksheet D Part II Date/Time Prepared: 7/28/2016 7:42 pm
	Title XVIII	Hospital	PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,174	1,293,368	0.034927	16,461	575	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	165	340,348	0.000485	4,949	2	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	88,534	1,667,277	0.053101	36,895	1,959	54.00
57.00	05700	CT SCAN	31,725	1,630,023	0.019463	73,186	1,424	57.00
58.00	05800	MRI	8,595	440,406	0.019516	9,958	194	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	20,598	2,334,818	0.008822	174,157	1,536	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	478	20,352	0.023487	4,434	104	62.00
65.00	06500	RESPIRATORY THERAPY	7,622	218,652	0.034859	79,257	2,763	65.00
66.00	06600	PHYSICAL THERAPY	9,673	265,812	0.036390	7,014	255	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,914	92,732	0.020640	8,728	180	67.00
68.00	06800	SPEECH PATHOLOGY	607	35,497	0.017100	5,195	89	68.00
69.00	06900	ELECTROCARDIOLOGY	6,040	474,992	0.012716	37,122	472	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,880	107,597	0.017473	33,422	584	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	144	50,956	0.002826	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,276	1,393,493	0.008810	221,245	1,949	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	31,591	2,205,762	0.014322	104,020	1,490	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	14,232	404,002	0.035228	13,229	466	92.00
200.00		Total (lines 50-199)	281,248	12,976,087		829,272	14,042	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet D Part III Date/Time Prepared: 7/28/2016 7:42 pm

Title XVIII | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			6.00	7.00	8.00	9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	380	0.00	138	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0	31.00
200.00		Total (lines 30-199)	380		138	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet D Part IV | Date/Time Prepared: 7/28/2016 7:42 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
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
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	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: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet D Part IV | Date/Time Prepared: 7/28/2016 7:42 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,293,368	0.000000	0.000000	16,461	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0	340,348	0.000000	0.000000	4,949	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,667,277	0.000000	0.000000	36,895	54.00
57.00	05700	CT SCAN	0	1,630,023	0.000000	0.000000	73,186	57.00
58.00	05800	MRI	0	440,406	0.000000	0.000000	9,958	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	2,334,818	0.000000	0.000000	174,157	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	20,352	0.000000	0.000000	4,434	62.00
65.00	06500	RESPIRATORY THERAPY	0	218,652	0.000000	0.000000	79,257	65.00
66.00	06600	PHYSICAL THERAPY	0	265,812	0.000000	0.000000	7,014	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	92,732	0.000000	0.000000	8,728	67.00
68.00	06800	SPEECH PATHOLOGY	0	35,497	0.000000	0.000000	5,195	68.00
69.00	06900	ELECTROCARDIOLOGY	0	474,992	0.000000	0.000000	37,122	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	107,597	0.000000	0.000000	33,422	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	50,956	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,393,493	0.000000	0.000000	221,245	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	2,205,762	0.000000	0.000000	104,020	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	404,002	0.000000	0.000000	13,229	92.00
200.00		Total (lines 50-199)	0	12,976,087			829,272	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet D Part IV | Date/Time Prepared: 7/28/2016 7:42 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	363,894	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	102,502	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	372,156	0	54.00
57.00	05700	CT SCAN	0	440,064	0	57.00
58.00	05800	MRI	0	84,972	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	332,585	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	8,338	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	20,425	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	152,121	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	23,410	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,643	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	234,457	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
91.00	09100	EMERGENCY	0	490,334	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	162,031	0	92.00
200.00		Total (lines 50-199)	0	2,795,932	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet D Part V Date/Time Prepared: 7/28/2016 7:42 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.415552	363,894	0	0	151,217	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.012420	102,502	0	0	1,273	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.520401	372,156	0	0	193,670	54.00
57.00	05700	CT SCAN	0.054292	440,064	0	0	23,892	57.00
58.00	05800	MRI	0.196818	84,972	0	0	16,724	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.211691	332,585	0	0	70,405	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.798202	8,338	0	0	6,655	62.00
65.00	06500	RESPIRATORY THERAPY	0.678892	20,425	0	0	13,866	65.00
66.00	06600	PHYSICAL THERAPY	0.444984	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.571367	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.332930	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.180837	152,121	0	0	27,509	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.523658	23,410	0	0	12,259	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.082777	8,643	0	0	715	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272242	234,457	0	10,089	63,829	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.280917	490,334	0	0	137,743	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.608014	162,031	0	0	98,517	92.00
200.00		Subtotal (see instructions)		2,795,932	0	10,089	818,274	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		2,795,932	0	10,089	818,274	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet D Part V | Date/Time Prepared: 7/28/2016 7:42 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,747	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	92.00
200.00		Subtotal (see instructions)	0	2,747	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	2,747	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet D Part I Date/Time Prepared: 7/28/2016 7:42 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	37,043	0	37,043	380	97.48	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
200.00	Total (lines 30-199)	37,043		37,043	380		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
200.00	Total (lines 30-199)	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 150102	Period: From 01/01/2016 To 02/29/2016	Worksheet D Part II Date/Time Prepared: 7/28/2016 7:42 pm
	Title XIX	Hospital	PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,174	1,293,368	0.034927	31,338	1,095	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	165	340,348	0.000485	5,148	2	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	88,534	1,667,277	0.053101	17,709	940	54.00
57.00	05700	CT SCAN	31,725	1,630,023	0.019463	22,404	436	57.00
58.00	05800	MRI	8,595	440,406	0.019516	5,975	117	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	20,598	2,334,818	0.008822	56,912	502	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	478	20,352	0.023487	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	7,622	218,652	0.034859	26,293	917	65.00
66.00	06600	PHYSICAL THERAPY	9,673	265,812	0.036390	402	15	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,914	92,732	0.020640	402	8	67.00
68.00	06800	SPEECH PATHOLOGY	607	35,497	0.017100	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,040	474,992	0.012716	9,331	119	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,880	107,597	0.017473	6,075	106	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	144	50,956	0.002826	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,276	1,393,493	0.008810	77,303	681	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	31,591	2,205,762	0.014322	35,813	513	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	14,232	404,002	0.035228	4,830	170	92.00
200.00		Total (lines 50-199)	281,248	12,976,087		299,935	5,621	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet D Part III | Date/Time Prepared: 7/28/2016 7:42 pm

Title XIX | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			6.00	7.00	8.00	9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	380	0.00	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0	31.00
200.00		Total (lines 30-199)	380		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet D Part IV | Date/Time Prepared: 7/28/2016 7:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
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
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	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: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet D Part IV | Date/Time Prepared: 7/28/2016 7:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,293,368	0.000000	0.000000	31,338	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0	340,348	0.000000	0.000000	5,148	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,667,277	0.000000	0.000000	17,709	54.00
57.00	05700	CT SCAN	0	1,630,023	0.000000	0.000000	22,404	57.00
58.00	05800	MRI	0	440,406	0.000000	0.000000	5,975	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	2,334,818	0.000000	0.000000	56,912	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	20,352	0.000000	0.000000	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	218,652	0.000000	0.000000	26,293	65.00
66.00	06600	PHYSICAL THERAPY	0	265,812	0.000000	0.000000	402	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	92,732	0.000000	0.000000	402	67.00
68.00	06800	SPEECH PATHOLOGY	0	35,497	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	474,992	0.000000	0.000000	9,331	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	107,597	0.000000	0.000000	6,075	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	50,956	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,393,493	0.000000	0.000000	77,303	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	2,205,762	0.000000	0.000000	35,813	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	404,002	0.000000	0.000000	4,830	92.00
200.00		Total (lines 50-199)	0	12,976,087			299,935	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet D Part IV | Date/Time Prepared: 7/28/2016 7:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	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: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet D Part V Date/Time Prepared: 7/28/2016 7:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.415552	0	345,379	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.012420	0	86,857	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.520401	0	308,347	0	0	54.00
57.00	05700	CT SCAN	0.054292	0	340,536	0	0	57.00
58.00	05800	MRI	0.196818	0	117,500	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.211691	0	534,997	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.798202	0	3,032	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.678892	0	16,082	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.444984	0	75,907	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.571367	0	49,346	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.332930	0	20,665	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.180837	0	102,689	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.523658	0	13,305	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.082777	0	15,320	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272242	0	274,487	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.280917	0	840,702	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.608014	0	89,881	0	0	92.00
200.00		Subtotal (see instructions)		0	3,235,032	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	3,235,032	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet D Part V Date/Time Prepared: 7/28/2016 7:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	143,523	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1,079	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	160,464	0	54.00
57.00	05700	CT SCAN	18,488	0	57.00
58.00	05800	MRI	23,126	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	113,254	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	2,420	0	62.00
65.00	06500	RESPIRATORY THERAPY	10,918	0	65.00
66.00	06600	PHYSICAL THERAPY	33,777	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,195	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,880	0	68.00
69.00	06900	ELECTROCARDIOLOGY	18,570	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	6,967	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,268	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	74,727	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	236,167	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	54,649	0	92.00
200.00		Subtotal (see instructions)	934,472	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	934,472	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet D-1 | Date/Time Prepared: 7/28/2016 7:42 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	380	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	380	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)	234	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	138	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	639,336	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	639,336	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)	639,336	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)	1,682.46	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	232,179	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)	232,179	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet D-1 | Date/Time Prepared: 7/28/2016 7:42 pm

Title XVIII | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	260,327	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	492,506	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)	13,452	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	14,042	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	27,494	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	465,012	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)	146	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,682.46	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	245,639	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet D-1 | Date/Time Prepared: 7/28/2016 7:42 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	37,043	639,336	0.057940	245,639	14,232	90.00
91.00	Nursing School cost	0	639,336	0.000000	245,639	0	91.00
92.00	Allied health cost	0	639,336	0.000000	245,639	0	92.00
93.00	All other Medical Education	0	639,336	0.000000	245,639	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet D-1 | Date/Time Prepared: 7/28/2016 7:42 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	380	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	380	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)	234	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	639,336	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	639,336	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)	639,336	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)	1,682.46	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet D-1 | Date/Time Prepared: 7/28/2016 7:42 pm

Title XIX | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	94,781	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	94,781	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)	5,621	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	5,621	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	89,160	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)	146	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,682.46	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	245,639	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150102	Period: From 01/01/2016 To 02/29/2016	Worksheet D-1 Date/Time Prepared: 7/28/2016 7:42 pm
	Title XIX	Hospital	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	37,043	639,336	0.057940	245,639	14,232	90.00
91.00	Nursing School cost	0	639,336	0.000000	245,639	0	91.00
92.00	Allied health cost	0	639,336	0.000000	245,639	0	92.00
93.00	All other Medical Education	0	639,336	0.000000	245,639	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 150102	Period: From 01/01/2016 To 02/29/2016	Worksheet D-3 Date/Time Prepared: 7/28/2016 7:42 pm
	Title XVIII	Hospital	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		214,993		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.415552	16,461	6,840	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.012420	4,949	61	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.520401	36,895	19,200	54.00
57.00	05700	CT SCAN	0.054292	73,186	3,973	57.00
58.00	05800	MRI	0.196818	9,958	1,960	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.212295	174,157	36,973	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.798202	4,434	3,539	62.00
65.00	06500	RESPIRATORY THERAPY	0.678892	79,257	53,807	65.00
66.00	06600	PHYSICAL THERAPY	0.444984	7,014	3,121	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.571367	8,728	4,987	67.00
68.00	06800	SPEECH PATHOLOGY	0.332930	5,195	1,730	68.00
69.00	06900	ELECTROCARDIOLOGY	0.180837	37,122	6,713	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.523658	33,422	17,502	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.082777	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272242	221,245	60,232	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.304233	104,020	31,646	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.608014	13,229	8,043	92.00
200.00		Total (sum of lines 50-94 and 96-98)		829,272	260,327	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)		829,272		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet D-3 | Date/Time Prepared: 7/28/2016 7:42 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		55,899		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.415552	31,338	13,023	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.012420	5,148	64	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.520401	17,709	9,216	54.00
57.00	05700	CT SCAN	0.054292	22,404	1,216	57.00
58.00	05800	MRI	0.196818	5,975	1,176	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.212295	56,912	12,082	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.798202	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.678892	26,293	17,850	65.00
66.00	06600	PHYSICAL THERAPY	0.444984	402	179	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.571367	402	230	67.00
68.00	06800	SPEECH PATHOLOGY	0.332930	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.180837	9,331	1,687	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.523658	6,075	3,181	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.082777	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.272242	77,303	21,045	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.304233	35,813	10,895	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.608014	4,830	2,937	92.00
200.00		Total (sum of lines 50-94 and 96-98)		299,935	94,781	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)		299,935		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet E Part A Date/Time Prepared: 7/28/2016 7:42 pm

Title XVIII | Hospital | PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	266,484	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	0	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	0	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	47.57	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	8.01	30.00
31.00	Percentage of Medicaid patient days (see instructions)	14.96	31.00
32.00	Sum of lines 30 and 31	22.97	32.00
33.00	Allowable disproportionate share percentage (see instructions)	8.17	33.00
34.00	Disproportionate share adjustment (see instructions)	5,443	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150102	Period: From 01/01/2016 To 02/29/2016	Worksheet E Part A Date/Time Prepared: 7/28/2016 7:42 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	0	35.00
35.01	Factor 3 (see instructions)	0.000011127	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	71,284	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	11,686	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	11,686		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	283,613		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	256,517		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	283,613	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	21,310	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	304,923	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	304,923	61.00
62.00	Deductibles billed to program beneficiaries	45,052	62.00
63.00	Coinsurance billed to program beneficiaries	0	63.00
64.00	Allowable bad debts (see instructions)	15,746	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	10,235	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	6,491	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	270,106	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	RURAL DEMONSTRATION PROJECT	0	70.50
70.88	SCH or MDH volume decrease adjustment	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	1,438	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet E Part A Date/Time Prepared: 7/28/2016 7:42 pm

Title XVIII | Hospital | PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2016	65,776	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		337,320	71.00
71.01	Sequestration adjustment (see instructions)		6,746	71.01
72.00	Interim payments		325,789	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		4,785	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		652	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	1.0053960754	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	1.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 7/28/2016 7:42 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	266,484	0	266,484	0	266,484	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0	0	0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0817	0.0817	0.0817	0.0817		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	5,443	0	5,443	0	5,443	11.00
11.01	Uncompensated care payments	36.00	11,686	0	11,686	0	11,686	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	283,613	0	283,613	0	283,613	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	256,517	0	256,517	0	256,517	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	283,613	0	283,613	0	283,613	15.00
16.00	Payment for inpatient program capital	50.00	21,310	0	21,310	0	21,310	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet E Part A Exhibit 4 | Date/Time Prepared: 7/28/2016 7:42 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	304,923	0	304,923	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	21,310	0	21,310	0	21,310	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	21,310	0	21,310	0	21,310	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.215714	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			65,776		65,776	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150102	Period: From 01/01/2016 To 02/29/2016	Worksheet E Part B Date/Time Prepared: 7/28/2016 7:42 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,747	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	818,274	2.00
3.00	PPS payments	407,247	3.00
4.00	Outlier payment (see instructions)	7,255	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)	2,747	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	10,089	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)	10,089	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)	10,089	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	7,342	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)	2,747	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)	414,502	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	107,708	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)	309,541	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)	309,541	30.00
31.00	Primary payer payments	19	31.00
32.00	Subtotal (line 30 minus line 31)	309,522	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)	42,792	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	27,815	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	34,803	36.00
37.00	Subtotal (see instructions)	337,337	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)	337,337	40.00
40.01	Sequestration adjustment (see instructions)	6,747	40.01
41.00	Interim payments	301,494	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	29,096	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	87	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: 150102	Period: From 01/01/2016 To 02/29/2016	Worksheet E-1 Part I Date/Time Prepared: 7/28/2016 7:42 pm
	Title XVIII	Hospital	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		325,789		301,494	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		325,789		301,494	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		4,785		29,096	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		330,574		330,590	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: 150102 | Component CCN: 15U102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet E-1 Part I | Date/Time Prepared: 7/28/2016 7:42 pm

Title XVIII | Swing Beds - SNF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		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		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		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: 150102	Period: From 01/01/2016 To 02/29/2016	Worksheet E-1 Part II Date/Time Prepared: 7/28/2016 7:42 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	0	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	0	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	0	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	0	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	0	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: 150102 Component CCN: 15U102	Period: From 01/01/2016 To 02/29/2016	Worksheet E-2 Date/Time Prepared: 7/28/2016 7:42 pm
	Title XVIII	Swing Beds - SNF	PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0	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)			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	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	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	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)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	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	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	0	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
20.00	Interim payments	0	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)	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet G | Date/Time Prepared: 7/28/2016 7:42 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2,111,142	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	14,616,742	0	0	0	4.00
5.00	Other receivable	492,477	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-11,162,812	0	0	0	6.00
7.00	Inventory	339,600	0	0	0	7.00
8.00	Prepaid expenses	74,763	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,471,912	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	142,789	0	0	0	12.00
13.00	Land improvements	37,448	0	0	0	13.00
14.00	Accumulated depreciation	-4,868	0	0	0	14.00
15.00	Buildings	1,509,571	0	0	0	15.00
16.00	Accumulated depreciation	-412,273	0	0	0	16.00
17.00	Leasehold improvements	6,082,400	0	0	0	17.00
18.00	Accumulated depreciation	-2,780,940	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	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	9,769,509	0	0	0	23.00
24.00	Accumulated depreciation	-7,104,976	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	7,238,660	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	13,710,572	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	-1,089,508	0	0	0	37.00
38.00	Salaries, wages, and fees payable	-540,731	0	0	0	38.00
39.00	Payroll taxes payable	-27,642	0	0	0	39.00
40.00	Notes and loans payable (short term)	-45,342	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	-86,268	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-1,789,491	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-1,789,491	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	15,500,063				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)	15,500,063	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	13,710,572	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet G-1 | Date/Time Prepared: 7/28/2016 7:42 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		14,547,460		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-7,969				2.00
3.00	Total (sum of line 1 and line 2)		14,539,491		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	DECREASE IN LIABILITIES	3,082,596		0		0	5.00
6.00	INTERCOMPANY CONTRIBUTIONS	7,969		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)		3,090,565		0		10.00
11.00	Subtotal (line 3 plus line 10)		17,630,056		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	DECREASE IN ASSETS	2,129,993		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)		2,129,993		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		15,500,063		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	DECREASE IN LIABILITIES		0		5.00
6.00	INTERCOMPANY CONTRIBUTIONS		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	DECREASE IN ASSETS		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: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 7/28/2016 7:42 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	573,015		573,015	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)	573,015		573,015	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	573,015		573,015	17.00
18.00	Ancillary services	1,341,197	9,025,126	10,366,323	18.00
19.00	Outpatient services	241,399	2,368,365	2,609,764	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	PROFESSIONAL	538	1,014,941	1,015,479	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,156,149	12,408,432	14,564,581	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		3,538,933		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)		3,538,933		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 150102 | Period: From 01/01/2016 To 02/29/2016 | Worksheet G-3 | Date/Time Prepared: 7/28/2016 7:42 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	14,564,581	1.00
2.00	Less contractual allowances and discounts on patients' accounts	11,147,854	2.00
3.00	Net patient revenues (line 1 minus line 2)	3,416,727	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	3,538,933	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-122,206	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	114,237	24.00
25.00	Total other income (sum of lines 6-24)	114,237	25.00
26.00	Total (line 5 plus line 25)	-7,969	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)	-7,969	29.00

CALCULATION OF CAPITAL PAYMENT

	Provider CCN: 150102	Period: From 01/01/2016 To 02/29/2016	Worksheet L Parts I-III Date/Time Prepared: 7/28/2016 7:42 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	21,310	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	3.90	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	21,310	12.00

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

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