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

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1312	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/25/2017 11:43 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/25/2017 Time: 11:43 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH WHITE HOSPITAL (15-1312) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

CHIEF FINANCIAL OFFICER
Title

05/26/2017
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-56,626	160,102	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	-66,337	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-122,963	160,102	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/22/2017 2:46 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 720 SOUTH SIXTH STREET	PO Box:			1.00
2.00	City: MONTICELLO	State: IN	Zip Code: 47960	County: WHITE	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 WHITE HOSPITAL	151312	99915	1	07/01/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	IU HEALTH WHITE HOSPITAL	15Z312	99915		02/16/1990	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	HOME CARE OF WHITE COUNTY	157514	99915		03/01/1997	N	N	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2016	12/31/2016	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2017 2:46 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.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2017 2:46 pm

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

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2017 2:46 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.	Y	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

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

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	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:	44,309	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2017 2:46 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: INDIANA UNIVERSITY HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST 10TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46202	143.00

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1312	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/22/2017 2:46 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2016	12/31/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	Y	28	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 5/22/2017 2:46 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.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/03/2017	Y	04/03/2017 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 5/22/2017 2:46 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.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA		UTTER		41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.962.1093		RUTTER@IUHEALTH.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1312	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/22/2017 2:46 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.	GOVERNMENT PROGRAMS DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/22/2017 2:46 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,686	29,424.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,686	29,424.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,464	6,312.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,150	35,736.00	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	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/22/2017 2:46 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,001	11	1,226			1.00
2.00	HMO and other (see instructions)	185	67				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	311	0	311			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	57			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,312	11	1,594			7.00
8.00	INTENSIVE CARE UNIT	80	0	263			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	1,392	11	1,857	0.00	131.19	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	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	131.19	27.00
28.00	Observation Bed Days		114	960			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/22/2017 2:46 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	353	4	540	1.00
2.00	HMO and other (see instructions)			58	23		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	353	4	540	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 5/22/2017 2:46 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)	0.323372	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,958,083	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	12,402,081	6.00
7.00	Medicaid cost (line 1 times line 6)	4,010,486	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,052,403	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,052,403	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	2,376,658	51,082	2,427,740	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	768,545	16,518	785,063	21.00
22.00	Partial payment by patients approved for charity care	31,546	5,980	37,526	22.00
23.00	Cost of charity care (line 21 minus line 22)	736,999	10,538	747,537	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,257,067	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	387,742	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,869,325	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	604,487	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,352,024	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,404,427	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/22/2017 2:46 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		2,044,692	2,044,692	-2,033,112	11,580	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL		0	0	2,650,943	2,650,943	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB		0	0	288,133	288,133	1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-394,646	48,530	-346,116	1,337,270	991,154	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,347,328	4,436,851	5,784,179	-18,123	5,766,056	5.00
7.00	00700	OPERATION OF PLANT	182,076	1,297,882	1,479,958	-905,623	574,335	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	0	0	826,196	826,196	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	0	0	260,840	260,840	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	63,471	63,471	8.00
9.00	00900	HOUSEKEEPING	295,960	248,169	544,129	-184,517	359,612	9.00
10.00	01000	DIETARY	495,306	362,967	858,273	-308,084	550,189	10.00
11.00	01100	CAFETERIA	0	0	0	110,508	110,508	11.00
13.00	01300	NURSING ADMINISTRATION	580,678	207,628	788,306	-98,355	689,951	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	20,468	20,468	476,540	497,008	14.00
15.00	01500	PHARMACY	366,704	1,715,126	2,081,830	-1,624,291	457,539	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	810,448	595,056	1,405,504	-252,445	1,153,059	30.00
31.00	03100	INTENSIVE CARE UNIT	176,605	65,767	242,372	-52,091	190,281	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	436,254	741,919	1,178,173	-363,600	814,573	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	340,721	315,197	655,918	-243,832	412,086	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	60,733	89,691	150,424	-53,716	96,708	55.00
56.00	05600	RADIOISOTOPE	108,484	120,421	228,905	-76,607	152,298	56.00
57.00	05700	CT SCAN	178,201	149,212	327,413	-101,275	226,138	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	89,580	114,999	204,579	-108,071	96,508	58.00
60.00	06000	LABORATORY	0	1,264,391	1,264,391	0	1,264,391	60.00
66.00	06600	PHYSICAL THERAPY	277,691	116,307	393,998	-70,015	323,983	66.00
67.00	06700	OCCUPATIONAL THERAPY	97,317	22,833	120,150	-15,253	104,897	67.00
68.00	06800	SPEECH PATHOLOGY	70,632	18,377	89,009	-13,299	75,710	68.00
69.00	06900	ELECTROCARDIOLOGY	77,420	36,457	113,877	-27,561	86,316	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,703	4,703	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,287	7,287	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,598,306	1,598,306	73.00
76.00	03020	CARDIOPULMONARY	341,489	127,460	468,949	-100,917	368,032	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	128,779	86,003	214,782	-32,406	182,376	90.00
91.00	09100	EMERGENCY	1,141,700	1,314,939	2,456,639	-358,021	2,098,618	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	198,053	25,249	223,302	-10,613	212,689	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,407,513	15,586,591	22,994,104	572,370	23,566,474	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	83,551	29,010	112,561	-23,397	89,164	192.00
192.02	19202	MOB	0	548,973	548,973	-548,973	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	7,491,064	16,164,574	23,655,638	0	23,655,638	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/22/2017 2:46 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	144,387	155,967		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	256,346	2,907,289		1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	366,578	654,711		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	76,161	1,067,315		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	612,341	6,378,397		5.00
7.00	00700	OPERATION OF PLANT	0	574,335		7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	826,196		7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	260,840		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	63,471		8.00
9.00	00900	HOUSEKEEPING	0	359,612		9.00
10.00	01000	DIETARY	-210,460	339,729		10.00
11.00	01100	CAFETERIA	-83,727	26,781		11.00
13.00	01300	NURSING ADMINISTRATION	-34,159	655,792		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-10,052	486,956		14.00
15.00	01500	PHARMACY	-8,982	448,557		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-245,452	907,607		30.00
31.00	03100	INTENSIVE CARE UNIT	0	190,281		31.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-44,736	769,837		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,369	409,717		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	96,708		55.00
56.00	05600	RADIOISOTOPE	0	152,298		56.00
57.00	05700	CT SCAN	0	226,138		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	96,508		58.00
60.00	06000	LABORATORY	0	1,264,391		60.00
66.00	06600	PHYSICAL THERAPY	-4,218	319,765		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	104,897		67.00
68.00	06800	SPEECH PATHOLOGY	0	75,710		68.00
69.00	06900	ELECTROCARDIOLOGY	0	86,316		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,703		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,287		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,598,306		73.00
76.00	03020	CARDIOPULMONARY	-1,855	366,177		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	182,376		90.00
91.00	09100	EMERGENCY	0	2,098,618		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	212,689		92.01
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	809,803	24,376,277		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	89,164		192.00
192.02	19202	MOB	0	0		192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0		192.04
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118-199)	809,803	24,465,441		200.00

RECLASSIFICATIONS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/22/2017 2:46 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	81,573	28,935		1.00
	0		81,573	28,935		
	B - DRUGS EXPENSE					
1.00	PHARMACY	15.00	0	2,995		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,598,306		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
	0		0	1,601,301		
	C - MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	481,934		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	4,703		2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	7,287		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
	0		0	493,924		
	D - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	63,471		1.00
2.00		0.00	0	0		2.00
	0		0	63,471		
	E - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	1,512,675		1.00
2.00	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	0	256,233		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00

RECLASSIFICATIONS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/22/2017 2:46 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
	0		0	1,768,908		
	F - OTHER CAPITAL EXPENSES					
1.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	1,116,074		1.00
2.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	21,544		2.00
3.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	650		3.00
4.00	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	0	31,900		4.00
5.00		0.00	0	0		5.00
	TOTALS		0	1,170,168		
	G - OPERATION OF PLANT					
1.00	OPERATION OF PLANT - HOSPITAL	7.01	0	847,013		1.00
2.00	OPERATION OF PLANT - TLMOB	7.02	0	260,840		2.00
	0		0	1,107,853		
	H - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,344,013		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
	0		0	1,344,013		
	I - HOUSEKEEPING SUPPLIES					
1.00	HOUSEKEEPING	9.00	0	6,820		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
	0		0	6,820		
	J - NON-CAPITAL EXPENSES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	113,384		1.00
	TOTALS		0	113,384		
500.00	Grand Total: Increases		81,573	7,698,777		500.00

RECLASSIFICATIONS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/22/2017 2:46 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	81,573	28,935	0		1.00
	0		81,573	28,935			
	B - DRUGS EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,989	0		1.00
2.00	PHARMACY	15.00	0	1,547,171	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	4,904	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	2,205	0		4.00
5.00	OPERATING ROOM	50.00	0	2,315	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	817	0		6.00
7.00	RADIOLOGY-THERAPEUTIC	55.00	0	23,559	0		7.00
8.00	RADIOISOTOPE	56.00	0	2,190	0		8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,891	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	23	0		10.00
11.00	ELECTROCARDIOLOGY	69.00	0	432	0		11.00
12.00	CARDIOPULMONARY	76.00	0	623	0		12.00
13.00	CLINIC	90.00	0	818	0		13.00
14.00	EMERGENCY	91.00	0	9,350	0		14.00
15.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	14	0		15.00
	0		0	1,601,301			
	C - MEDICAL SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	105	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	490	0		2.00
3.00	OPERATION OF PLANT - HOSPITAL	7.01	0	20,817	0		3.00
4.00	HOUSEKEEPING	9.00	0	29,498	0		4.00
5.00	DIETARY	10.00	0	2,979	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	2,554	0		6.00
7.00	PHARMACY	15.00	0	8,824	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	55,825	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	11,227	0		9.00
10.00	OPERATING ROOM	50.00	0	137,720	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,094	0		11.00
12.00	RADIOLOGY-THERAPEUTIC	55.00	0	1,162	0		12.00
13.00	RADIOISOTOPE	56.00	0	3,778	0		13.00
14.00	CT SCAN	57.00	0	38,585	0		14.00
15.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	6,707	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	7,215	0		16.00
17.00	OCCUPATIONAL THERAPY	67.00	0	667	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	3,558	0		18.00
19.00	CARDIOPULMONARY	76.00	0	13,503	0		19.00
20.00	CLINIC	90.00	0	5,816	0		20.00
21.00	EMERGENCY	91.00	0	132,008	0		21.00
22.00	OBSERVATION BEDS (DISTINCT PART)	92.01	0	2,355	0		22.00
23.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,437	0		23.00
	0		0	493,924			
	D - LAUNDRY						
1.00	HOUSEKEEPING	9.00	0	58,884	0		1.00
2.00	DIETARY	10.00	0	4,587	0		2.00
	0		0	63,471			
	E - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	782,149	9		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,649	9		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	27,059	0		3.00
4.00	OPERATION OF PLANT	7.00	0	10,857	0		4.00
5.00	DIETARY	10.00	0	56,150	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,345	0		6.00
7.00	PHARMACY	15.00	0	28,813	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	36,037	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	259	0		9.00
10.00	OPERATING ROOM	50.00	0	126,251	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	175,329	0		11.00
12.00	RADIOLOGY-THERAPEUTIC	55.00	0	16,095	0		12.00
13.00	RADIOISOTOPE	56.00	0	57,520	0		13.00
14.00	CT SCAN	57.00	0	32,479	0		14.00
15.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	78,181	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	4,461	0		16.00
17.00	OCCUPATIONAL THERAPY	67.00	0	120	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	11,330	0		18.00
19.00	CARDIOPULMONARY	76.00	0	1,289	0		19.00

RECLASSIFICATIONS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/22/2017 2:46 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
20.00	CLINIC	90.00	0	29	0	20.00
21.00	EMERGENCY	91.00	0	59,346	0	21.00
22.00	OBSERVATION BEDS (DISTINCT PART)	92.01	0	232	0	22.00
23.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,695	0	23.00
24.00	MOB	192.02	0	256,233	0	24.00
	0		0	1,768,908		
	F - OTHER CAPITAL EXPENSES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,116,035	11	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	21,544	12	2.00
3.00	PHARMACY	15.00	0	650	13	3.00
4.00	MOB	192.02	0	31,900	13	4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	39	11	5.00
	TOTALS		0	1,170,168		
	G - OPERATION OF PLANT					
1.00	OPERATION OF PLANT	7.00	0	847,013	0	1.00
2.00	MOB	192.02	0	260,840	0	2.00
	0		0	1,107,853		
	H - EMPLOYEE BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	103,919	0	1.00
2.00	OPERATION OF PLANT	7.00	0	47,753	0	2.00
3.00	HOUSEKEEPING	9.00	0	102,955	0	3.00
4.00	DIETARY	10.00	0	128,316	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	95,592	0	5.00
6.00	PHARMACY	15.00	0	41,419	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	155,423	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	38,400	0	8.00
9.00	OPERATING ROOM	50.00	0	97,150	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	62,548	0	10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	12,900	0	11.00
12.00	RADIOISOTOPE	56.00	0	13,115	0	12.00
13.00	CT SCAN	57.00	0	30,211	0	13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	21,292	0	14.00
15.00	PHYSICAL THERAPY	66.00	0	58,316	0	15.00
16.00	OCCUPATIONAL THERAPY	67.00	0	14,466	0	16.00
17.00	SPEECH PATHOLOGY	68.00	0	13,295	0	17.00
18.00	ELECTROCARDIOLOGY	69.00	0	12,241	0	18.00
19.00	CARDIOPULMONARY	76.00	0	85,502	0	19.00
20.00	CLINIC	90.00	0	25,710	0	20.00
21.00	EMERGENCY	91.00	0	157,213	0	21.00
22.00	OBSERVATION BEDS (DISTINCT PART)	92.01	0	8,026	0	22.00
23.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	18,251	0	23.00
	0		0	1,344,013		
	I - HOUSEKEEPING SUPPLIES					
1.00	DIETARY	10.00	0	5,544	0	1.00
2.00	NURSING ADMINISTRATION	13.00	0	209	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	49	0	3.00
4.00	PHARMACY	15.00	0	409	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	256	0	5.00
6.00	OPERATING ROOM	50.00	0	164	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	44	0	7.00
8.00	RADIOISOTOPE	56.00	0	4	0	8.00
9.00	SPEECH PATHOLOGY	68.00	0	4	0	9.00
10.00	CLINIC	90.00	0	33	0	10.00
11.00	EMERGENCY	91.00	0	104	0	11.00
	0		0	6,820		
	J - NON-CAPITAL EXPENSES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	113,384	12	1.00
	TOTALS		0	113,384		
500.00	Grand Total: Decreases		81,573	7,698,777		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 5/22/2017 2:46 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	954,570	0	0	0	0	1.00
2.00	Land Improvements	1,948,206	0	0	0	712,186	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	40,540,941	0	0	0	68,120	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	4,173,860	864,351	0	864,351	154,787	6.00
7.00	HIT designated Assets	78,430	0	0	0	63,430	7.00
8.00	Subtotal (sum of lines 1-7)	47,696,007	864,351	0	864,351	998,523	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	47,696,007	864,351	0	864,351	998,523	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	954,570	0	1.00
2.00	Land Improvements	1,236,020	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	40,472,821	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	4,883,424	174,992	6.00
7.00	HIT designated Assets	15,000	15,000	7.00
8.00	Subtotal (sum of lines 1-7)	47,561,835	189,992	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	47,561,835	189,992	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part II | Date/Time Prepared: 5/22/2017 2:46 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	793,728	0	1,116,036	134,928	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	0	0	0	1.02
3.00	Total (sum of lines 1-2)	793,728	0	1,116,036	134,928	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	2,044,692	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	1.02
3.00	Total (sum of lines 1-2)	0	2,044,692	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 5/22/2017 2:46 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	2,190,590	0	2,190,590	0.046058	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	29,732,383	0	29,732,383	0.625131	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	15,638,863	0	15,638,863	0.328811	0	1.02
3.00	Total (sum of lines 1-2)	47,561,836	0	47,561,836	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	155,966	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	0	1,674,440	90,840	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	0	622,811	0	1.02
3.00	Total (sum of lines 1-2)	0	0	0	2,453,217	90,840	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	1	0	0	0	155,967	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1,119,815	21,544	650	0	2,907,289	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	31,900	0	654,711	1.02
3.00	Total (sum of lines 1-2)	1,119,816	21,544	32,550	0	3,717,967	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/22/2017 2:46 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)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - HOSPITAL (chapter 2)	B	-30,696	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	11	1.01
1.02	Investment income - CAP REL COSTS-BLDG & FIXT - TLMOB (chapter 2)		0	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-262,458			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	2,758,530			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-51,676	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	144,387	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - HOSPITAL	A	105,725	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	26.01
26.02	Depreciation - CAP REL COSTS-BLDG & FIXT - TLMOB	A	366,578	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	9	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/22/2017 2:46 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	
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	A	-41,488	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	32.00
33.00	EMPLOYEE BENEFITS	A	-1,346,418	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	INVESTMENT FEES	A	1,302	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	ROUTINE CAPITAL LEASE	A	45,143	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	10	33.02
33.03	DIETARY CAPITAL LEASE	A	45,697	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	10	33.03
33.04	ROUTINE LEASES	A	17,006	ADULTS & PEDIATRICS	30.00	0	33.04
33.05	SURGERY LEASES	A	82,153	OPERATING ROOM	50.00	0	33.05
33.06	LOSS ON ABANDONMENT	A	97,528	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	33.06
33.07	CATERING / OTHER REVENUE	B	-32,051	CAFETERIA	11.00	0	33.07
33.08	MEDICAID HAF FEES	A	-594,543	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	MISCELLANEOUS INCOME	B	-6,769	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	MISCELLANEOUS INCOME	B	-8,515	NURSING ADMINISTRATION	13.00	0	33.10
33.11	MISCELLANEOUS INCOME	B	-10,052	CENTRAL SERVICES & SUPPLY	14.00	0	33.11
33.12	MISCELLANEOUS INCOME	B	-8,982	PHARMACY	15.00	0	33.12
33.13	MISCELLANEOUS INCOME	B	-2,970	OPERATING ROOM	50.00	0	33.13
33.14	MISCELLANEOUS INCOME	B	-2,369	RADIOLOGY-DIAGNOSTIC	54.00	0	33.14
33.15	MISCELLANEOUS INCOME	B	-4,218	PHYSICAL THERAPY	66.00	0	33.15
33.16	MISCELLANEOUS INCOME	B	-1,855	CARDIOPULMONARY	76.00	0	33.16
33.17	WIC PROGRAM COSTS	A	-210,460	DIETARY	10.00	0	33.17
33.18	WIC PROGRAM BENEFIT COSTS	A	-27,238	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.18
33.19	CRNA COSTS	A	-123,919	OPERATING ROOM	50.00	0	33.19
33.20	ACCRUED PTO - HR	A	394,646	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21	ACCRUED PTO - GENERAL	A	-472,715	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	CONTRIBUTION EXPENSE	A	-9,500	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23			0		0.00	0	33.23
33.24			0		0.00	0	33.24
33.25			0		0.00	0	33.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		809,803				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/22/2017 2:46 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	1.01	CAP REL COSTS-BLDG & FIXT -	BUILDING CAPITAL-HO DIRECT C	1,150,473	1,116,036	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS-HOME OFFIC	1,055,171	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	A&G HOME OFFICE AND ARNETT	3,275,968	3,798,204	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	A&G ARNETT ALLOCATION	2,088,108	0	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	A&G HO POOLED CAPITAL	128,694	0	3.02
4.00	13.00	NURSING ADMINISTRATION	EDUCATION-HOME OFFICE	0	25,644	4.00
4.01	30.00	ADULTS & PEDIATRICS	A&P - SHARED EMPLOYEES	277,199	277,199	4.01
4.02	50.00	OPERATING ROOM	OR - SHARED EMPLOYEES	283,958	283,958	4.02
4.03	56.00	RADIOISOTOPE	RADIOISOTOPE - SHARED EMPLOY	31,200	31,200	4.03
4.04	60.00	LABORATORY	LAB - SHARED EMPLOYEES	1,228,843	1,228,843	4.04
4.05	69.00	ELECTROCARDIOLOGY	ECG - SHARED EMPLOYEES	31,200	31,200	4.05
4.06	192.00	PHYSICIANS' PRIVATE OFFICES	PHYSICIAN OFFICES - SHARED E	25,265	25,265	4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,576,079	6,817,549	5.00

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

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

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

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

6.00	B	IU HEALTH	100.00		0.00	6.00
7.00	B	IUH ARNETT	1.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/22/2017 2:46 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	34,437	11		1.00
2.00	1,055,171	0		2.00
3.00	-522,236	0		3.00
3.01	2,088,108	0		3.01
3.02	128,694	0		3.02
4.00	-25,644	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
5.00	2,758,530			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 5/22/2017 2:46 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	30.00	ADULTS & PEDIATRICS	262,458	262,458	0	0	0	1.00
2.00	60.00	LABORATORY	-938	0	-938	0	0	2.00
3.00	90.00	CLINIC	22,500	0	22,500	0	0	3.00
4.00	91.00	EMERGENCY	855,607	0	855,607	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,139,627	262,458	877,169		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	262,458		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	90.00	CLINIC	0	0	0	0		3.00
4.00	91.00	EMERGENCY	0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	262,458		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/22/2017 2:46 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					10	1.00
2.00	Line 1 multiplied by 15 hours per week					150	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					47	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					4.82	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	0.00	374.75	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	0.00	80.10	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	0.00	0.00	40.05			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					0	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					30,017	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					30,017	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					30,017	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					30,017	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					1,882	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					1,882	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					227	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					2,109	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					2,109	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/22/2017 2:46 pm

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	0.00	80.10	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	30,017	57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	2,109	58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00	
60.00	Overtime allowance (from column 5, line 56)	0	60.00	
61.00	Equipment cost (see instructions)	0	61.00	
62.00	Supplies (see instructions)	0	62.00	
63.00	Total allowance (sum of lines 57-62)	32,126	63.00	
64.00	Total cost of outside supplier services (from your records)	20,237	64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00	
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	1,882	100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	227	100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27	2,109	100.02	
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	227	101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01	
101.02	Line 34 = sum of lines 27 and 31	227	101.02	
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01	
102.02	Line 35 = sum of lines 31 and 32	0	102.02	

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/22/2017 2:46 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - TLMOB	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	1.02	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	155,967	155,967				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	2,907,289	0	2,907,289			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	654,711	0	0	654,711		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,067,315	0	0	0	1,067,315	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,378,397	17,261	80,821	161,940	182,356	5.00
7.00	00700	OPERATION OF PLANT	574,335	0	0	0	24,644	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	826,196	20,532	614,781	0	0	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	260,840	13,177	0	146,540	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	63,471	531	15,893	0	0	8.00
9.00	00900	HOUSEKEEPING	359,612	1,962	54,458	1,595	40,058	9.00
10.00	01000	DIETARY	339,729	4,524	0	50,311	55,998	10.00
11.00	01100	CAFETERIA	26,781	1,458	0	16,211	11,041	11.00
13.00	01300	NURSING ADMINISTRATION	655,792	518	0	5,763	78,594	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	486,956	4,691	140,476	0	0	14.00
15.00	01500	PHARMACY	448,557	2,004	59,994	0	49,633	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	907,607	14,360	429,977	0	109,693	30.00
31.00	03100	INTENSIVE CARE UNIT	190,281	1,482	44,365	0	23,903	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	769,837	12,619	377,854	0	59,046	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	409,717	5,823	174,371	0	46,116	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	96,708	660	19,772	0	8,220	55.00
56.00	05600	RADIOISOTOPE	152,298	455	13,633	0	14,683	56.00
57.00	05700	CT SCAN	226,138	621	18,605	0	24,119	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	96,508	877	26,250	0	12,124	58.00
60.00	06000	LABORATORY	1,264,391	3,242	97,090	0	0	60.00
66.00	06600	PHYSICAL THERAPY	319,765	2,826	84,625	0	37,585	66.00
67.00	06700	OCCUPATIONAL THERAPY	104,897	225	6,741	0	13,172	67.00
68.00	06800	SPEECH PATHOLOGY	75,710	106	3,164	0	9,560	68.00
69.00	06900	ELECTROCARDIOLOGY	86,316	655	19,621	0	10,479	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,703	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,287	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,598,306	0	0	0	0	73.00
76.00	03020	CARDIOPULMONARY	366,177	1,815	54,345	0	46,220	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	182,376	2,034	60,898	0	17,430	90.00
91.00	09100	EMERGENCY	2,098,618	8,202	245,588	0	154,527	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	212,689	8,816	263,967	0	26,806	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,376,277	131,476	2,907,289	382,360	1,056,007	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	89,164	5,001	0	55,612	11,308	192.00
192.02	19202	MOB	0	16,171	0	179,828	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	3,319	0	36,911	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	24,465,441	155,967	2,907,289	654,711	1,067,315	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/22/2017 2:46 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - TLMOB	
			4A	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,820,775	6,820,775				5.00
7.00	00700	OPERATION OF PLANT	598,979	231,543	830,522			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	1,461,509	564,965	122,936	2,149,410		7.01
7.02	00702	OPERATION OF PLANT - TLMOB	420,557	162,572	78,902	0	662,031	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	79,895	30,884	3,178	15,445	0	8.00
9.00	00900	HOUSEKEEPING	457,685	176,924	11,748	52,925	3,049	9.00
10.00	01000	DIETARY	450,562	174,171	27,089	0	96,200	10.00
11.00	01100	CAFETERIA	55,491	21,451	8,728	0	30,997	11.00
13.00	01300	NURSING ADMINISTRATION	740,667	286,314	3,103	0	11,019	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	632,123	244,355	28,090	136,520	0	14.00
15.00	01500	PHARMACY	560,188	216,548	11,997	58,305	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,461,637	565,015	85,981	417,870	0	30.00
31.00	03100	INTENSIVE CARE UNIT	260,031	100,518	8,871	43,116	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,219,356	471,358	75,558	367,214	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	636,027	245,865	34,868	169,461	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	125,360	48,460	3,954	19,215	0	55.00
56.00	05600	RADIOISOTOPE	181,069	69,995	2,726	13,249	0	56.00
57.00	05700	CT SCAN	269,483	104,172	3,720	18,081	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	135,759	52,479	5,249	25,511	0	58.00
60.00	06000	LABORATORY	1,364,723	527,551	19,415	94,356	0	60.00
66.00	06600	PHYSICAL THERAPY	444,801	171,944	16,922	82,242	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	125,035	48,334	1,348	6,552	0	67.00
68.00	06800	SPEECH PATHOLOGY	88,540	34,226	633	3,074	0	68.00
69.00	06900	ELECTROCARDIOLOGY	117,071	45,255	3,924	19,069	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,703	1,818	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,287	2,817	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,598,306	617,846	0	0	0	73.00
76.00	03020	CARDIOPULMONARY	468,557	181,127	10,867	52,815	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	262,738	101,565	12,178	59,183	0	90.00
91.00	09100	EMERGENCY	2,506,935	969,088	49,109	238,673	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	512,278	198,028	52,785	256,534	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,068,127	6,667,188	683,879	2,149,410	141,265	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	161,085	62,270	29,943	0	106,336	192.00
192.02	19202	MOB	195,999	75,766	96,826	0	343,852	192.02
192.03	19203	ARNETT SURGERY OFFICE	40,230	15,551	19,874	0	70,578	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	24,465,441	6,820,775	830,522	2,149,410	662,031	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/22/2017 2:46 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	129,402					8.00
9.00	00900	HOUSEKEEPING	1,525	703,856				9.00
10.00	01000	DIETARY	735	28,351	777,108			10.00
11.00	01100	CAFETERIA	234	8,968	0	125,869		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	10,916	1,052,019	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,472	0	0	0	14.00
15.00	01500	PHARMACY	0	26,037	0	5,812	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,500	122,661	667,049	23,354	282,200	30.00
31.00	03100	INTENSIVE CARE UNIT	9,115	34,715	110,059	3,313	88,385	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,562	99,228	0	9,526	118,854	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,626	24,879	0	8,925	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	254	2,893	0	1,283	0	55.00
56.00	05600	RADIOISOTOPE	962	2,025	0	1,764	0	56.00
57.00	05700	CT SCAN	1,862	2,604	0	3,981	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	295	3,761	0	2,298	0	58.00
60.00	06000	LABORATORY	199	40,212	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	2,810	23,144	0	6,814	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	543	1,736	0	1,349	0	67.00
68.00	06800	SPEECH PATHOLOGY	192	868	0	935	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,336	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIOPULMONARY	1,236	24,012	0	9,446	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	982	14,175	0	3,033	0	90.00
91.00	09100	EMERGENCY	49,423	107,329	0	24,610	442,302	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	804	27,772	0	4,502	120,278	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	128,859	598,842	777,108	123,197	1,052,019	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	543	0	0	2,672	0	192.00
192.02	19202	MOB	0	105,014	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	129,402	703,856	777,108	125,869	1,052,019	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/22/2017 2:46 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
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	1,044,560					14.00
15.00	01500	PHARMACY	19,654	898,541				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	123,107	0	0	3,791,374	0	30.00
31.00	03100	INTENSIVE CARE UNIT	23,520	0	0	681,643	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	247,151	0	0	2,617,807	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,567	0	0	1,136,218	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,434	0	0	203,853	0	55.00
56.00	05600	RADIOISOTOPE	6,796	0	0	278,586	0	56.00
57.00	05700	CT SCAN	85,016	0	0	488,919	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	14,051	0	0	239,403	0	58.00
60.00	06000	LABORATORY	0	0	0	2,046,456	0	60.00
66.00	06600	PHYSICAL THERAPY	14,562	0	0	763,239	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,209	0	0	186,106	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	128,468	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,454	0	0	194,109	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	136,808	0	0	143,329	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,266	0	0	25,370	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	898,541	0	3,114,693	0	73.00
76.00	03020	CARDIOPULMONARY	28,068	0	0	776,128	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	12,184	0	0	466,038	0	90.00
91.00	09100	EMERGENCY	284,579	0	0	4,672,048	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	4,934	0	0	1,177,915	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,037,360	898,541	0	23,131,702	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,200	0	0	370,049	0	192.00
192.02	19202	MOB	0	0	0	817,457	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	146,233	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,044,560	898,541	0	24,465,441	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/22/2017 2:46 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL			7.01
7.02	00702	OPERATION OF PLANT - TLMOB			7.02
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	3,791,374		30.00
31.00	03100	INTENSIVE CARE UNIT	681,643		31.00
43.00	04300	NURSERY	0		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,617,807		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,136,218		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	203,853		55.00
56.00	05600	RADIOISOTOPE	278,586		56.00
57.00	05700	CT SCAN	488,919		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	239,403		58.00
60.00	06000	LABORATORY	2,046,456		60.00
66.00	06600	PHYSICAL THERAPY	763,239		66.00
67.00	06700	OCCUPATIONAL THERAPY	186,106		67.00
68.00	06800	SPEECH PATHOLOGY	128,468		68.00
69.00	06900	ELECTROCARDIOLOGY	194,109		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	143,329		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,370		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,114,693		73.00
76.00	03020	CARDIOPULMONARY	776,128		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	466,038		90.00
91.00	09100	EMERGENCY	4,672,048		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,177,915		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,131,702		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	370,049		192.00
192.02	19202	MOB	817,457		192.02
192.03	19203	ARNETT SURGERY OFFICE	146,233		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0		192.04
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	24,465,441		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/22/2017 2:46 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - TLMOB	Subtotal	
			0	1.00	1.01	1.02	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	128,694	17,261	80,821	161,940	388,716	5.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	20,532	614,781	0	635,313	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	13,177	0	146,540	159,717	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	531	15,893	0	16,424	8.00
9.00	00900	HOUSEKEEPING	0	1,962	54,458	1,595	58,015	9.00
10.00	01000	DIETARY	0	4,524	0	50,311	54,835	10.00
11.00	01100	CAFETERIA	0	1,458	0	16,211	17,669	11.00
13.00	01300	NURSING ADMINISTRATION	0	518	0	5,763	6,281	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,691	140,476	0	145,167	14.00
15.00	01500	PHARMACY	0	2,004	59,994	0	61,998	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	14,360	429,977	0	444,337	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,482	44,365	0	45,847	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	12,619	377,854	0	390,473	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,823	174,371	0	180,194	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	660	19,772	0	20,432	55.00
56.00	05600	RADIOISOTOPE	0	455	13,633	0	14,088	56.00
57.00	05700	CT SCAN	0	621	18,605	0	19,226	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	877	26,250	0	27,127	58.00
60.00	06000	LABORATORY	0	3,242	97,090	0	100,332	60.00
66.00	06600	PHYSICAL THERAPY	0	2,826	84,625	0	87,451	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	225	6,741	0	6,966	67.00
68.00	06800	SPEECH PATHOLOGY	0	106	3,164	0	3,270	68.00
69.00	06900	ELECTROCARDIOLOGY	0	655	19,621	0	20,276	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIOPULMONARY	0	1,815	54,345	0	56,160	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,034	60,898	0	62,932	90.00
91.00	09100	EMERGENCY	0	8,202	245,588	0	253,790	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	8,816	263,967	0	272,783	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	128,694	131,476	2,907,289	382,360	3,549,819	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,001	0	55,612	60,613	192.00
192.02	19202	MOB	0	16,171	0	179,828	195,999	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	3,319	0	36,911	40,230	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	128,694	155,967	2,907,289	654,711	3,846,661	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/22/2017 2:46 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - TLMOB	
			4.00	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	388,716				5.00
7.00	00700	OPERATION OF PLANT	0	13,196	13,196			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	32,197	1,955	669,465		7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	9,265	1,254	0	170,236	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,760	50	4,811	0	8.00
9.00	00900	HOUSEKEEPING	0	10,083	187	16,484	784	9.00
10.00	01000	DIETARY	0	9,926	430	0	24,737	10.00
11.00	01100	CAFETERIA	0	1,222	139	0	7,971	11.00
13.00	01300	NURSING ADMINISTRATION	0	16,317	49	0	2,833	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	13,926	446	42,521	0	14.00
15.00	01500	PHARMACY	0	12,341	191	18,160	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	32,200	1,366	130,151	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,728	141	13,429	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	26,862	1,201	114,374	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,012	554	52,781	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,762	63	5,985	0	55.00
56.00	05600	RADIOISOTOPE	0	3,989	43	4,127	0	56.00
57.00	05700	CT SCAN	0	5,937	59	5,632	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,991	83	7,946	0	58.00
60.00	06000	LABORATORY	0	30,065	308	29,389	0	60.00
66.00	06600	PHYSICAL THERAPY	0	9,799	269	25,615	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,755	21	2,041	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,951	10	958	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,579	62	5,939	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	104	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	161	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	35,211	0	0	0	73.00
76.00	03020	CARDIOPULMONARY	0	10,322	173	16,450	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,788	193	18,433	0	90.00
91.00	09100	EMERGENCY	0	55,229	780	74,338	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	11,285	839	79,901	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	379,963	10,866	669,465	36,325	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,549	476	0	27,343	192.00
192.02	19202	MOB	0	4,318	1,538	0	88,419	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	886	316	0	18,149	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	0	388,716	13,196	669,465	170,236	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/22/2017 2:46 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	23,045					8.00
9.00	00900	HOUSEKEEPING	272	85,825				9.00
10.00	01000	DIETARY	131	3,457	93,516			10.00
11.00	01100	CAFETERIA	42	1,094	0	28,137		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	2,440	27,920	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	423	0	0	0	14.00
15.00	01500	PHARMACY	0	3,175	0	1,299	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,569	14,957	80,272	5,221	7,489	30.00
31.00	03100	INTENSIVE CARE UNIT	1,623	4,233	13,244	741	2,346	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,703	12,099	0	2,129	3,154	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,002	3,034	0	1,995	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	45	353	0	287	0	55.00
56.00	05600	RADIOISOTOPE	171	247	0	394	0	56.00
57.00	05700	CT SCAN	332	317	0	890	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	53	459	0	514	0	58.00
60.00	06000	LABORATORY	35	4,903	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	500	2,822	0	1,523	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	97	212	0	302	0	67.00
68.00	06800	SPEECH PATHOLOGY	34	106	0	209	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	299	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIOPULMONARY	220	2,928	0	2,112	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	175	1,728	0	678	0	90.00
91.00	09100	EMERGENCY	8,801	13,087	0	5,501	11,739	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	143	3,386	0	1,006	3,192	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,948	73,020	93,516	27,540	27,920	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	97	0	0	597	0	192.00
192.02	19202	MOB	0	12,805	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	23,045	85,825	93,516	28,137	27,920	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/22/2017 2:46 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
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	202,483					14.00
15.00	01500	PHARMACY	3,810	100,974				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,864	0	0	747,426	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,559	0	0	91,891	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	47,909	0	0	599,904	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,048	0	0	255,620	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	472	0	0	30,399	0	55.00
56.00	05600	RADIOISOTOPE	1,317	0	0	24,376	0	56.00
57.00	05700	CT SCAN	16,480	0	0	48,873	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,724	0	0	41,897	0	58.00
60.00	06000	LABORATORY	0	0	0	165,032	0	60.00
66.00	06600	PHYSICAL THERAPY	2,823	0	0	130,802	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	234	0	0	12,628	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	6,538	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,445	0	0	30,600	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,520	0	0	26,624	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,959	0	0	3,120	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100,974	0	136,185	0	73.00
76.00	03020	CARDIOPULMONARY	5,441	0	0	93,806	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,362	0	0	92,289	0	90.00
91.00	09100	EMERGENCY	55,164	0	0	478,429	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	956	0	0	373,491	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	201,087	100,974	0	3,389,930	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,396	0	0	94,071	0	192.00
192.02	19202	MOB	0	0	0	303,079	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	59,581	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	202,483	100,974	0	3,846,661	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/22/2017 2:46 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL			7.01
7.02	00702	OPERATION OF PLANT - TLMOB			7.02
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	747,426		30.00
31.00	03100	INTENSIVE CARE UNIT	91,891		31.00
43.00	04300	NURSERY	0		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	599,904		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	255,620		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	30,399		55.00
56.00	05600	RADIOISOTOPE	24,376		56.00
57.00	05700	CT SCAN	48,873		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	41,897		58.00
60.00	06000	LABORATORY	165,032		60.00
66.00	06600	PHYSICAL THERAPY	130,802		66.00
67.00	06700	OCCUPATIONAL THERAPY	12,628		67.00
68.00	06800	SPEECH PATHOLOGY	6,538		68.00
69.00	06900	ELECTROCARDIOLOGY	30,600		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,624		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,120		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	136,185		73.00
76.00	03020	CARDIOPULMONARY	93,806		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	92,289		90.00
91.00	09100	EMERGENCY	478,429		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	373,491		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,389,930		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	94,071		192.00
192.02	19202	MOB	303,079		192.02
192.03	19203	ARNETT SURGERY OFFICE	59,581		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0		192.04
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	3,846,661		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/22/2017 2:46 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - HOSPITAL (SQUARE FEET)	BLDG & FIXT - TLMOB (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	1.02	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	124,005					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	77,196				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	46,809			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	7,885,710		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,724	2,146	11,578	1,347,328	-6,820,775	5.00
7.00	00700	OPERATION OF PLANT	0	0	0	182,076	0	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	16,324	16,324	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	10,477	0	10,477	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	422	422	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,560	1,446	114	295,960	0	9.00
10.00	01000	DIETARY	3,597	0	3,597	413,733	0	10.00
11.00	01100	CAFETERIA	1,159	0	1,159	81,573	0	11.00
13.00	01300	NURSING ADMINISTRATION	412	0	412	580,678	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,730	3,730	0	0	0	14.00
15.00	01500	PHARMACY	1,593	1,593	0	366,704	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,417	11,417	0	810,448	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,178	1,178	0	176,605	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,033	10,033	0	436,254	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,630	4,630	0	340,721	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	525	525	0	60,733	0	55.00
56.00	05600	RADIOISOTOPE	362	362	0	108,484	0	56.00
57.00	05700	CT SCAN	494	494	0	178,201	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	697	697	0	89,580	0	58.00
60.00	06000	LABORATORY	2,578	2,578	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	2,247	2,247	0	277,691	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	179	179	0	97,317	0	67.00
68.00	06800	SPEECH PATHOLOGY	84	84	0	70,632	0	68.00
69.00	06900	ELECTROCARDIOLOGY	521	521	0	77,420	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIOPULMONARY	1,443	1,443	0	341,489	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,617	1,617	0	128,779	0	90.00
91.00	09100	EMERGENCY	6,521	6,521	0	1,141,700	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	7,009	7,009	0	198,053	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	104,533	77,196	27,337	7,802,159	-6,820,775	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,976	0	3,976	83,551	0	192.00
192.02	19202	MOB	12,857	0	12,857	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	2,639	0	2,639	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	155,967	2,907,289	654,711	1,067,315		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.257748	37.661135	13.986862	0.135348		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/22/2017 2:46 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL (SQUARE FEET)	OPERATION OF PLANT - TLMOB (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5.00	7.00	7.01	7.02	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,644,666					5.00
7.00	00700	OPERATION OF PLANT	598,979	110,281				7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	1,461,509	16,324	58,726			7.01
7.02	00702	OPERATION OF PLANT - TLMOB	420,557	10,477	0	24,754		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	79,895	422	422	0	18,838	8.00
9.00	00900	HOUSEKEEPING	457,685	1,560	1,446	114	222	9.00
10.00	01000	DIETARY	450,562	3,597	0	3,597	107	10.00
11.00	01100	CAFETERIA	55,491	1,159	0	1,159	34	11.00
13.00	01300	NURSING ADMINISTRATION	740,667	412	0	412	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	632,123	3,730	3,730	0	0	14.00
15.00	01500	PHARMACY	560,188	1,593	1,593	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,461,637	11,417	11,417	0	6,187	30.00
31.00	03100	INTENSIVE CARE UNIT	260,031	1,178	1,178	0	1,327	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,219,356	10,033	10,033	0	1,392	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	636,027	4,630	4,630	0	819	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	125,360	525	525	0	37	55.00
56.00	05600	RADIOISOTOPE	181,069	362	362	0	140	56.00
57.00	05700	CT SCAN	269,483	494	494	0	271	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	135,759	697	697	0	43	58.00
60.00	06000	LABORATORY	1,364,723	2,578	2,578	0	29	60.00
66.00	06600	PHYSICAL THERAPY	444,801	2,247	2,247	0	409	66.00
67.00	06700	OCCUPATIONAL THERAPY	125,035	179	179	0	79	67.00
68.00	06800	SPEECH PATHOLOGY	88,540	84	84	0	28	68.00
69.00	06900	ELECTROCARDIOLOGY	117,071	521	521	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,703	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,287	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,598,306	0	0	0	0	73.00
76.00	03020	CARDIOPULMONARY	468,557	1,443	1,443	0	180	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	262,738	1,617	1,617	0	143	90.00
91.00	09100	EMERGENCY	2,506,935	6,521	6,521	0	7,195	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	512,278	7,009	7,009	0	117	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,247,352	90,809	58,726	5,282	18,759	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	161,085	3,976	0	3,976	79	192.00
192.02	19202	MOB	195,999	12,857	0	12,857	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	40,230	2,639	0	2,639	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	6,820,775	830,522	2,149,410	662,031	129,402	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.386563	7.530962	36.600654	26.744405	6.869201	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	388,716	13,196	669,465	170,236	23,045	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.022030	0.119658	11.399806	6.877111	1.223325	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/22/2017 2:46 pm

		Cost Center Description	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	2,433					9.00
10.00	01000	DIETARY	98	1,857				10.00
11.00	01100	CAFETERIA	31	0	9,421			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	817	61,287		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12	0	0	0	498,618	14.00
15.00	01500	PHARMACY	90	0	435	0	9,382	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	424	1,594	1,748	16,440	58,765	30.00
31.00	03100	INTENSIVE CARE UNIT	120	263	248	5,149	11,227	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	343	0	713	6,924	117,977	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	86	0	668	0	5,044	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	10	0	96	0	1,162	55.00
56.00	05600	RADIOISOTOPE	7	0	132	0	3,244	56.00
57.00	05700	CT SCAN	9	0	298	0	40,582	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13	0	172	0	6,707	58.00
60.00	06000	LABORATORY	139	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	80	0	510	0	6,951	66.00
67.00	06700	OCCUPATIONAL THERAPY	6	0	101	0	577	67.00
68.00	06800	SPEECH PATHOLOGY	3	0	70	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	100	0	3,558	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	65,305	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	7,287	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIOPULMONARY	83	0	707	0	13,398	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	49	0	227	0	5,816	90.00
91.00	09100	EMERGENCY	371	0	1,842	25,767	135,844	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	96	0	337	7,007	2,355	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,070	1,857	9,221	61,287	495,181	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	200	0	3,437	192.00
192.02	19202	MOB	363	0	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	703,856	777,108	125,869	1,052,019	1,044,560	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	289.295520	418.474960	13.360471	17.165451	2.094910	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	85,825	93,516	28,137	27,920	202,483	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	35.275380	50.358643	2.986626	0.455562	0.406088	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/22/2017 2:46 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			15.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB				1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL				7.01
7.02	00702	OPERATION OF PLANT - TLMOB				7.02
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	0		73.00
76.00	03020	CARDIOPULMONARY	0	0		76.00
		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 PART)				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.02	19202	MOB	0	0		192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0		192.04
193.00	19300	NONPAID WORKERS	0	0		193.00
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)	898,541	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8,985.410000	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	100,974	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1,009.740000	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/22/2017 2:46 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,791,374		3,791,374	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	681,643		681,643	0	0	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,617,807		2,617,807	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,136,218		1,136,218	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	203,853		203,853	0	0	55.00
56.00	05600	RADIOISOTOPE	278,586		278,586	0	0	56.00
57.00	05700	CT SCAN	488,919		488,919	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	239,403		239,403	0	0	58.00
60.00	06000	LABORATORY	2,046,456		2,046,456	0	0	60.00
66.00	06600	PHYSICAL THERAPY	763,239	0	763,239	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	186,106	0	186,106	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	128,468	0	128,468	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	194,109		194,109	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	143,329		143,329	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,370		25,370	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,114,693		3,114,693	0	0	73.00
76.00	03020	CARDIOPULMONARY	776,128		776,128	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	466,038		466,038	0	0	90.00
91.00	09100	EMERGENCY	4,672,048		4,672,048	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,454,630		1,454,630		0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,177,915		1,177,915	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	24,586,332	0	24,586,332	0	0	200.00
201.00		Less Observation Beds	1,454,630		1,454,630		0	201.00
202.00		Total (see instructions)	23,131,702	0	23,131,702	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/22/2017 2:46 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,699,428		2,699,428			30.00
31.00	03100	INTENSIVE CARE UNIT	399,348		399,348			31.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,760	5,817,756	5,835,516	0.448599	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	105,334	5,653,485	5,758,819	0.197301	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	13,030	972,929	985,959	0.206756	0.000000	55.00
56.00	05600	RADIOISOTOPE	227,867	2,219,817	2,447,684	0.113816	0.000000	56.00
57.00	05700	CT SCAN	186,841	4,341,065	4,527,906	0.107979	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	60,336	1,042,593	1,102,929	0.217061	0.000000	58.00
60.00	06000	LABORATORY	1,014,103	6,202,377	7,216,480	0.283581	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	270,179	1,003,846	1,274,025	0.599077	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	110,765	159,657	270,422	0.688206	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	20,122	173,231	193,353	0.664422	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	180,392	3,666,401	3,846,793	0.050460	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,940	362,331	369,271	0.388140	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	109,595	109,595	0.231489	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,747,094	8,907,375	10,654,469	0.292337	0.000000	73.00
76.00	03020	CARDIOPULMONARY	380,144	447,642	827,786	0.937595	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	684,001	684,001	0.681341	0.000000	90.00
91.00	09100	EMERGENCY	195,940	16,209,784	16,405,724	0.284782	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	15,355	3,784,410	3,799,765	0.382821	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	105,333	2,018,149	2,123,482	0.554709	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	7,756,311	63,776,444	71,532,755			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,756,311	63,776,444	71,532,755			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/22/2017 2:46 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	CARDIOPULMONARY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/22/2017 2:46 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,791,374		3,791,374	0	3,791,374	30.00
31.00	03100	INTENSIVE CARE UNIT	681,643		681,643	0	681,643	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,617,807		2,617,807	0	2,617,807	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,136,218		1,136,218	0	1,136,218	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	203,853		203,853	0	203,853	55.00
56.00	05600	RADIOISOTOPE	278,586		278,586	0	278,586	56.00
57.00	05700	CT SCAN	488,919		488,919	0	488,919	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	239,403		239,403	0	239,403	58.00
60.00	06000	LABORATORY	2,046,456		2,046,456	0	2,046,456	60.00
66.00	06600	PHYSICAL THERAPY	763,239	0	763,239	0	763,239	66.00
67.00	06700	OCCUPATIONAL THERAPY	186,106	0	186,106	0	186,106	67.00
68.00	06800	SPEECH PATHOLOGY	128,468	0	128,468	0	128,468	68.00
69.00	06900	ELECTROCARDIOLOGY	194,109		194,109	0	194,109	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	143,329		143,329	0	143,329	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,370		25,370	0	25,370	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,114,693		3,114,693	0	3,114,693	73.00
76.00	03020	CARDIOPULMONARY	776,128		776,128	0	776,128	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	466,038		466,038	0	466,038	90.00
91.00	09100	EMERGENCY	4,672,048		4,672,048	0	4,672,048	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,454,630		1,454,630		1,454,630	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,177,915		1,177,915	0	1,177,915	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	24,586,332	0	24,586,332	0	24,586,332	200.00
201.00		Less Observation Beds	1,454,630		1,454,630		1,454,630	201.00
202.00		Total (see instructions)	23,131,702	0	23,131,702	0	23,131,702	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/22/2017 2:46 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,699,428		2,699,428			30.00
31.00	03100	INTENSIVE CARE UNIT	399,348		399,348			31.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,760	5,817,756	5,835,516	0.448599	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	105,334	5,653,485	5,758,819	0.197301	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	13,030	972,929	985,959	0.206756	0.000000	55.00
56.00	05600	RADIOISOTOPE	227,867	2,219,817	2,447,684	0.113816	0.000000	56.00
57.00	05700	CT SCAN	186,841	4,341,065	4,527,906	0.107979	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	60,336	1,042,593	1,102,929	0.217061	0.000000	58.00
60.00	06000	LABORATORY	1,014,103	6,202,377	7,216,480	0.283581	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	270,179	1,003,846	1,274,025	0.599077	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	110,765	159,657	270,422	0.688206	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	20,122	173,231	193,353	0.664422	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	180,392	3,666,401	3,846,793	0.050460	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,940	362,331	369,271	0.388140	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	109,595	109,595	0.231489	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,747,094	8,907,375	10,654,469	0.292337	0.000000	73.00
76.00	03020	CARDIOPULMONARY	380,144	447,642	827,786	0.937595	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	684,001	684,001	0.681341	0.000000	90.00
91.00	09100	EMERGENCY	195,940	16,209,784	16,405,724	0.284782	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	15,355	3,784,410	3,799,765	0.382821	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	105,333	2,018,149	2,123,482	0.554709	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	7,756,311	63,776,444	71,532,755			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,756,311	63,776,444	71,532,755			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/22/2017 2:46 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	CARDIOPULMONARY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/22/2017 2:46 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	599,904	5,835,516	0.102802	17,760	1,826	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	255,620	5,758,819	0.044388	56,945	2,528	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	30,399	985,959	0.030832	5,120	158	55.00
56.00	05600	RADIOISOTOPE	24,376	2,447,684	0.009959	154,044	1,534	56.00
57.00	05700	CT SCAN	48,873	4,527,906	0.010794	79,796	861	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	41,897	1,102,929	0.037987	31,984	1,215	58.00
60.00	06000	LABORATORY	165,032	7,216,480	0.022869	579,395	13,250	60.00
66.00	06600	PHYSICAL THERAPY	130,802	1,274,025	0.102668	124,489	12,781	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,628	270,422	0.046697	43,306	2,022	67.00
68.00	06800	SPEECH PATHOLOGY	6,538	193,353	0.033814	17,038	576	68.00
69.00	06900	ELECTROCARDIOLOGY	30,600	3,846,793	0.007955	107,822	858	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,624	369,271	0.072099	5,184	374	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,120	109,595	0.028468	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	136,185	10,654,469	0.012782	1,034,178	13,219	73.00
76.00	03020	CARDIOPULMONARY	93,806	827,786	0.113322	241,658	27,385	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	92,289	684,001	0.134925	0	0	90.00
91.00	09100	EMERGENCY	478,429	16,405,724	0.029162	14,215	415	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	286,764	3,799,765	0.075469	518	39	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	373,491	2,123,482	0.175886	4,668	821	92.01
200.00		Total (lines 50-199)	2,837,377	68,433,979		2,518,120	79,862	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/22/2017 2:46 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIOPULMONARY	0	0	0	0	0	76.00
		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 PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/22/2017 2:46 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,835,516	0.000000	0.000000	17,760	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,758,819	0.000000	0.000000	56,945	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	985,959	0.000000	0.000000	5,120	55.00
56.00	05600	RADIOISOTOPE	0	2,447,684	0.000000	0.000000	154,044	56.00
57.00	05700	CT SCAN	0	4,527,906	0.000000	0.000000	79,796	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,102,929	0.000000	0.000000	31,984	58.00
60.00	06000	LABORATORY	0	7,216,480	0.000000	0.000000	579,395	60.00
66.00	06600	PHYSICAL THERAPY	0	1,274,025	0.000000	0.000000	124,489	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	270,422	0.000000	0.000000	43,306	67.00
68.00	06800	SPEECH PATHOLOGY	0	193,353	0.000000	0.000000	17,038	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,846,793	0.000000	0.000000	107,822	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	369,271	0.000000	0.000000	5,184	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	109,595	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,654,469	0.000000	0.000000	1,034,178	73.00
76.00	03020	CARDIOPULMONARY	0	827,786	0.000000	0.000000	241,658	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	684,001	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	16,405,724	0.000000	0.000000	14,215	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,799,765	0.000000	0.000000	518	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	2,123,482	0.000000	0.000000	4,668	92.01
200.00		Total (lines 50-199)	0	68,433,979			2,518,120	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/22/2017 2:46 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	CARDIOPULMONARY	0	0	0		76.00
		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 PART)	0	0	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0		92.01
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/22/2017 2:46 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.448599	0	2,027,301	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197301	0	1,724,823	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.206756	0	495,671	0	0	55.00
56.00	05600	RADIOISOTOPE	0.113816	0	895,869	0	0	56.00
57.00	05700	CT SCAN	0.107979	0	1,469,871	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.217061	0	436,416	0	0	58.00
60.00	06000	LABORATORY	0.283581	0	2,589,573	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.599077	0	363,167	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.688206	0	38,147	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.664422	0	20,569	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.050460	0	1,556,050	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.388140	0	91,538	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.231489	0	37,197	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.292337	0	4,239,051	2,845	0	73.00
76.00	03020	CARDIOPULMONARY	0.937595	0	189,638	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.681341	0	441,371	0	0	90.00
91.00	09100	EMERGENCY	0.284782	0	4,517,043	1,231	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.382821	0	2,014,253	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.554709	0	964,907	0	0	92.01
200.00		Subtotal (see instructions)		0	24,112,455	4,076	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	24,112,455	4,076	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/22/2017 2:46 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	909,445	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	340,309	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	102,483	0		55.00
56.00	05600	RADIOISOTOPE	101,964	0		56.00
57.00	05700	CT SCAN	158,715	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	94,729	0		58.00
60.00	06000	LABORATORY	734,354	0		60.00
66.00	06600	PHYSICAL THERAPY	217,565	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	26,253	0		67.00
68.00	06800	SPEECH PATHOLOGY	13,666	0		68.00
69.00	06900	ELECTROCARDIOLOGY	78,518	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,530	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,611	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,239,231	832		73.00
76.00	03020	CARDIOPULMONARY	177,804	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	300,724	0		90.00
91.00	09100	EMERGENCY	1,286,373	351		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	771,098	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	535,243	0		92.01
200.00		Subtotal (see instructions)	7,132,615	1,183		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	7,132,615	1,183		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1312 | Component CCN: 15-Z312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/22/2017 2:46 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.448599	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197301	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.206756	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.113816	0	0	0	0	56.00
57.00	05700	CT SCAN	0.107979	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.217061	0	0	0	0	58.00
60.00	06000	LABORATORY	0.283581	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.599077	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.688206	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.664422	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.050460	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.388140	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.231489	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.292337	0	0	0	0	73.00
76.00	03020	CARDIOPULMONARY	0.937595	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.681341	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.284782	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.382821	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.554709	0	0	0	0	92.01
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1312 | Component CCN: 15-Z312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V | Date/Time Prepared: 5/22/2017 2:46 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020	CARDIOPULMONARY	0	0	76.00
		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 PART)	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/22/2017 2:46 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.448599	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197301	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.206756	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.113816	0	0	0	0	56.00
57.00	05700	CT SCAN	0.107979	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.217061	0	0	0	0	58.00
60.00	06000	LABORATORY	0.283581	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.599077	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.688206	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.664422	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.050460	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.388140	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.231489	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.292337	0	0	0	0	73.00
76.00	03020	CARDIOPULMONARY	0.937595	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.681341	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.284782	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.382821	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.554709	0	0	0	0	92.01
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/22/2017 2:46 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020	CARDIOPULMONARY	0	0	76.00
		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 PART)	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/22/2017 2:46 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,554	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,186	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,226	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	311	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	57	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,001	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)	311	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	137.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,791,374	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)	7,827	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)	479,067	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,312,307	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)	3,312,307	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)	1,515.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,516,755	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,516,755	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/22/2017 2:46 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	681,643	263	2,591.80	80	207,344	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)	876,551	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,600,650	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	471,240	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)	471,240	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)	960	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,515.24	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,454,630	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/22/2017 2:46 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	747,426	3,791,374	0.197139	1,454,630	286,764	90.00
91.00	Nursing School cost	0	3,791,374	0.000000	1,454,630	0	91.00
92.00	Allied health cost	0	3,791,374	0.000000	1,454,630	0	92.00
93.00	All other Medical Education	0	3,791,374	0.000000	1,454,630	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/22/2017 2:46 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,554	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,186	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,226	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	311	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	57	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)	11	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	137.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,791,374	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)	7,827	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)	479,067	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,312,307	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)	3,312,307	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)	1,515.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	16,668	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)	16,668	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/22/2017 2:46 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	681,643	263	2,591.80	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)	15,970	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	32,638	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	960	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,515.24	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,454,630	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/22/2017 2:46 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	747,426	3,791,374	0.197139	1,454,630	286,764	90.00
91.00	Nursing School cost	0	3,791,374	0.000000	1,454,630	0	91.00
92.00	Allied health cost	0	3,791,374	0.000000	1,454,630	0	92.00
93.00	All other Medical Education	0	3,791,374	0.000000	1,454,630	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/22/2017 2:46 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,440,801		30.00
31.00	03100	INTENSIVE CARE UNIT		282,882		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.448599	17,760	7,967	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197301	56,945	11,235	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.206756	5,120	1,059	55.00
56.00	05600	RADIOISOTOPE	0.113816	154,044	17,533	56.00
57.00	05700	CT SCAN	0.107979	79,796	8,616	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.217061	31,984	6,942	58.00
60.00	06000	LABORATORY	0.283581	579,395	164,305	60.00
66.00	06600	PHYSICAL THERAPY	0.599077	124,489	74,578	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.688206	43,306	29,803	67.00
68.00	06800	SPEECH PATHOLOGY	0.664422	17,038	11,320	68.00
69.00	06900	ELECTROCARDIOLOGY	0.050460	107,822	5,441	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.388140	5,184	2,012	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.231489	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.292337	1,034,178	302,328	73.00
76.00	03020	CARDIOPULMONARY	0.937595	241,658	226,577	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.681341	0	0	90.00
91.00	09100	EMERGENCY	0.284782	14,215	4,048	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.382821	518	198	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.554709	4,668	2,589	92.01
200.00		Total (sum of lines 50-94 and 96-98)		2,518,120	876,551	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)		2,518,120		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3

Component CCN: 15-Z312 | Date/Time Prepared: 5/22/2017 2:46 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.448599	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197301	3,628	716	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.206756	0	0	55.00
56.00	05600	RADIOISOTOPE	0.113816	3,156	359	56.00
57.00	05700	CT SCAN	0.107979	4,781	516	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.217061	0	0	58.00
60.00	06000	LABORATORY	0.283581	62,197	17,638	60.00
66.00	06600	PHYSICAL THERAPY	0.599077	95,254	57,064	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.688206	52,638	36,226	67.00
68.00	06800	SPEECH PATHOLOGY	0.664422	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.050460	2,190	111	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.388140	275	107	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.231489	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.292337	184,238	53,860	73.00
76.00	03020	CARDIOPULMONARY	0.937595	44,552	41,772	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.681341	0	0	90.00
91.00	09100	EMERGENCY	0.284782	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.382821	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.554709	0	0	92.01
200.00		Total (sum of lines 50-94 and 96-98)		452,909	208,369	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)		452,909		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/22/2017 2:46 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		18,551		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.448599	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197301	1,544	305	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.206756	0	0	55.00
56.00	05600	RADIOISOTOPE	0.113816	0	0	56.00
57.00	05700	CT SCAN	0.107979	3,520	380	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.217061	0	0	58.00
60.00	06000	LABORATORY	0.283581	12,421	3,522	60.00
66.00	06600	PHYSICAL THERAPY	0.599077	1,256	752	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.688206	398	274	67.00
68.00	06800	SPEECH PATHOLOGY	0.664422	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.050460	1,825	92	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.388140	501	194	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.231489	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.292337	19,810	5,791	73.00
76.00	03020	CARDIOPULMONARY	0.937595	2,068	1,939	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.681341	0	0	90.00
91.00	09100	EMERGENCY	0.284782	9,556	2,721	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.382821	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.554709	0	0	92.01
200.00		Total (sum of lines 50-94 and 96-98)		52,899	15,970	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)		52,899		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1312	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/22/2017 2:46 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,133,798	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,133,798	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	7,205,136	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	61,037	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	4,314,150	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,829,949	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,829,949	30.00
31.00	Primary payer payments	573	31.00
32.00	Subtotal (line 30 minus line 31)	2,829,376	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)	580,182	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	377,118	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	569,438	36.00
37.00	Subtotal (see instructions)	3,206,494	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,206,494	40.00
40.01	Sequestration adjustment (see instructions)	64,130	40.01
41.00	Interim payments	2,982,262	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	160,102	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I Date/Time Prepared: 5/22/2017 2:46 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,319,609		2,982,262	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)		2,319,609		2,982,262	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		160,102	6.01
6.02	SETTLEMENT TO PROGRAM		56,626		0	6.02
7.00	Total Medicare program liability (see instructions)		2,262,983		3,142,364	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1312 | Component CCN: 15-Z312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/22/2017 2:46 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		736,215		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)		736,215		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		66,337		0	6.02
7.00	Total Medicare program liability (see instructions)		669,878		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1312	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/22/2017 2:46 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	540	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,081	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	185	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,489	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	71,532,755	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	2,427,740	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1312 Component CCN: 15-Z312	Period: From 01/01/2016 To 12/31/2016	Worksheet E-2 Date/Time Prepared: 5/22/2017 2:46 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	475,952	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)	210,453	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	311	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)	686,405	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	686,405	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)	686,405	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,059	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)	683,346	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)	312	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	203	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	683,549	0	19.00
19.01	Sequestration adjustment (see instructions)	13,671	0	19.01
20.00	Interim payments	736,215	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)	-66,337	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1312	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part V Date/Time Prepared: 5/22/2017 2:46 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,600,650	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,600,650	4.00
5.00	Primary payer payments	3,364	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,623,293	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,623,293	19.00
20.00	Deductibles (exclude professional component)	324,548	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,298,745	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,298,745	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	16,033	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	10,421	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	13,601	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,309,166	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	2,309,166	30.00
30.01	Sequestration adjustment (see instructions)	46,183	30.01
31.00	Interim payments	2,319,609	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	-56,626	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	250,773	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 5/22/2017 2:46 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	19,466,840	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	2,319,830	0	0	0	4.00
5.00	Other receivable	908,355	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	274,032	0	0	0	7.00
8.00	Prepaid expenses	118,848	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)	23,087,905	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	972,779	0	0	0	12.00
13.00	Land improvements	122,178	0	0	0	13.00
14.00	Accumulated depreciation	-61,854	0	0	0	14.00
15.00	Buildings	30,187,561	0	0	0	15.00
16.00	Accumulated depreciation	-4,110,223	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	7,679,675	0	0	0	23.00
24.00	Accumulated depreciation	-4,140,388	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	30,649,728	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	315,844	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)	315,844	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	54,053,477	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	612,256	0	0	0	37.00
38.00	Salaries, wages, and fees payable	688,564	0	0	0	38.00
39.00	Payroll taxes payable	39,551	0	0	0	39.00
40.00	Notes and loans payable (short term)	560,000	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	1,999,506	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,899,877	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	21,525,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	399,626	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	21,924,626	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25,824,503	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	28,228,974				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)	28,228,974	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	54,053,477	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 5/22/2017 2:46 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		24,381,462		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,809,556				2.00
3.00	Total (sum of line 1 and line 2)		28,191,018		0		3.00
4.00	NET INTERCOMPANY TRANSACTIONS	37,957		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		37,957		0		10.00
11.00	Subtotal (line 3 plus line 10)		28,228,975		0		11.00
12.00	ROUNDING	1		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		1		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		28,228,974		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	NET INTERCOMPANY TRANSACTIONS		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	ROUNDING		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1312 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/22/2017 2:46 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,699,428		2,699,428	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,699,428		2,699,428	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	399,348		399,348	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)	399,348		399,348	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,098,776		3,098,776	17.00
18.00	Ancillary services	4,340,907	41,080,100	45,421,007	18.00
19.00	Outpatient services	316,628	22,696,344	23,012,972	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	0	3,337	3,337	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,756,311	63,779,781	71,536,092	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		23,655,638		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)		23,655,638		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1312	Period: From 01/01/2016 To 12/31/2016	Worksheet G-3 Date/Time Prepared: 5/22/2017 2:46 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	71,536,092	1.00
2.00	Less contractual allowances and discounts on patients' accounts	44,883,838	2.00
3.00	Net patient revenues (line 1 minus line 2)	26,652,254	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,655,638	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,996,616	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	812,940	24.00
25.00	Total other income (sum of lines 6-24)	812,940	25.00
26.00	Total (line 5 plus line 25)	3,809,556	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)	3,809,556	29.00