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: 15-0001	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 1/16/2018 3:01 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 1/16/2018 Time: 3:01 pm
2. [ ] Manually submitted cost report
3. [1] 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. [5] 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 JOHNSON MEMORIAL HOSPITAL (15-0001) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-60,415	79,366	0	-50,816	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	-5		9,568	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	19		0	9.00
200.00	Total	0	-60,415	79,380	0	-41,248	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: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 1/16/2018 3:01 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1125 WEST JEFFERSON STREET	PO Box:			1.00
2.00	City: FRANKLIN	State: IN	Zip Code: 46131-	County: JOHNSON	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	JOHNSON MEMORIAL HOSPITAL	150001	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	TODD AIKENS REHAB CENTER	15T001	26900	5	01/01/2005	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									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	JOHNSON MEMORIAL HOME HEALTH	157510	26900		07/01/1997	N	P	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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2016	12/31/2016	20.00
21.00	Type of Control (see instructions)	9		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	149	575	0	0	912	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.	13	72	0	0	72		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 1/16/2018 3:01 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 1/16/2018 3:01 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: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 1/16/2018 3:01 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)	N		0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			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)	N		0	76.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 1/16/2018 3:01 pm

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	396,754	63,412	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: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 1/16/2018 3:01 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)	N		140.00

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0001	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 1/16/2018 3:01 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)	01/01/2016	12/31/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 1/16/2018 3:01 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)	N			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)	Y	04/03/2017	Y	04/03/2017	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 1/16/2018 3:01 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		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.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		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.		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		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		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.		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.		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.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?			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.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			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.	AUSTIN	FISHER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3172757438	AFISHER@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0001	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 1/16/2018 3:01 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.	SENIOR ACCOUNTANT		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: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 1/16/2018 3:01 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	80	29,280	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		80	29,280	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,196	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		86	31,476	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	11	4,026		0	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)		97				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: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 1/16/2018 3:01 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)	2,551	69	5,437			1.00
2.00	HMO and other (see instructions)	679	1,406				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	27	144				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,551	69	5,437			7.00
8.00	INTENSIVE CARE UNIT	393	14	1,057			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		58	744			13.00
14.00	Total (see instructions)	2,944	141	7,238	0.00	547.98	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	649	13	1,461	0.00	9.72	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	4,153	157	6,443	0.00	9.59	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	567.29	27.00
28.00	Observation Bed Days		0	1,247			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	89	139			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: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 1/16/2018 3:01 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	783	29	2,053	1.00
2.00	HMO and other (see instructions)			176	516		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				1		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	783	29	2,053	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	52	9	103	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 WAGE INDEX INFORMATION | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 1/16/2018 3:01 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	38,906,469	2,012,370	40,918,839	1,328,596.00	30.80	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		184,531	0	184,531	1,792.00	102.97	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		899,024	0	899,024	12,015.00	74.83	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		12,573,178	299,767	12,872,945	285,759.00	45.05	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,190,875	0	1,190,875	15,277.00	77.95	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		363,802	0	363,802	4,113.00	88.45	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,316,477	0	7,316,477			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		2,031,767	0	2,031,767			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		12,738	0	12,738			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		85,425	0	85,425			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		0	0	0			25.50
25.51	Related orgainzation wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	3,081,956	332,869	3,414,825	172,298.00	19.82	26.00
27.00	Administrative & General	5.00	2,104,139	94,588	2,198,727	64,817.00	33.92	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 1/16/2018 3:01 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		224,148	0	224,148	3,030.00	73.98	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	653,588	31,979	685,567	32,900.00	20.84	30.00
31.00	Laundry & Linen Service	8.00	122,994	5,121	128,115	8,935.00	14.34	31.00
32.00	Housekeeping	9.00	650,679	42,234	692,913	56,055.00	12.36	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	802,380	-478,688	323,692	24,345.00	13.30	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	527,173	527,173	29,071.00	18.13	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,499,038	112,896	1,611,934	28,965.00	55.65	38.00
39.00	Central Services and Supply	14.00	82,725	6,667	89,392	4,088.00	21.87	39.00
40.00	Pharmacy	15.00	474,185	49,301	523,486	14,856.00	35.24	40.00
41.00	Medical Records & Medical Records Library	16.00	560,309	36,862	597,171	32,241.00	18.52	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part III Date/Time Prepared: 1/16/2018 3:01 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		38,231,593	2,012,370	40,243,963	1,319,611.00	30.50	1.00
2.00	Excluded area salaries (see instructions)		12,573,178	299,767	12,872,945	285,759.00	45.05	2.00
3.00	Subtotal salaries (line 1 minus line 2)		25,658,415	1,712,603	27,371,018	1,033,852.00	26.47	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,554,677	0	1,554,677	19,390.00	80.18	4.00
5.00	Subtotal wage-related costs (see inst.)		7,329,215	0	7,329,215	0.00	26.78	5.00
6.00	Total (sum of lines 3 thru 5)		34,542,307	1,712,603	36,254,910	1,053,242.00	34.42	6.00
7.00	Total overhead cost (see instructions)		10,256,141	761,002	11,017,143	471,601.00	23.36	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part IV Date/Time Prepared: 1/16/2018 3:01 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	958,631	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	44,568	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	5,419,425	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	25,600	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	144,613	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	233,542	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,552,986	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	7,436	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	11,293	22.00
23.00	Tuition Reimbursement	48,314	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,446,408	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part V Date/Time Prepared: 1/16/2018 3:01 pm

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

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-0001 | Component CCN: 15-7510 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-4 | Date/Time Prepared: 1/16/2018 3:01 pm

Home Health Agency I | PPS

						1.00	
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	209.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	1.95	0.00	1.95	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			1.57	0.00	1.57	5.00
6.00	Direct Nursing Service			4.03	0.00	4.03	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			2.37	0.00	2.37	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			1.06	0.00	1.06	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.04	0.00	0.04	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.01	0.00	0.01	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			3			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			18020			20.00
20.01				26900			20.01
20.02				50032			20.02
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,851	32	27	26	1,936	21.00
22.00	Skilled Nursing Visit Charges	443,090	7,680	6,480	6,170	463,420	22.00
23.00	Physical Therapy Visits	1,288	40	4	18	1,350	23.00
24.00	Physical Therapy Visit Charges	334,040	10,400	1,040	4,650	350,130	24.00
25.00	Occupational Therapy Visits	810	26	2	10	848	25.00
26.00	Occupational Therapy Visit Charges	210,080	6,760	520	2,570	219,930	26.00
27.00	Speech Pathology Visits	11	6	0	0	17	27.00
28.00	Speech Pathology Visit Charges	2,860	1,560	0	0	4,420	28.00
29.00	Medical Social Service Visits	2	0	0	0	2	29.00
30.00	Medical Social Service Visit Charges	560	0	0	0	560	30.00
31.00	Home Health Aide Visits	0	0	0	0	0	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,962	104	33	54	4,153	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	990,630	26,400	8,040	13,390	1,038,460	35.00
36.00	Total Number of Episodes (standard/non outlier)	225		11	2	238	36.00
37.00	Total Number of Outlier Episodes		2		0	2	37.00
38.00	Total Non-Routine Medical Supply Charges	91	0	0	0	91	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 1/16/2018 3:01 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)	0.295219	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,228,979	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	28,336,273	6.00
7.00	Medicaid cost (line 1 times line 6)	8,365,406	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)	4,136,427	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
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (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)	4,136,427	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	3,806,152	0	3,806,152	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,123,648	0	1,123,648	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,123,648	0	1,123,648	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, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,225,030	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	172,106	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	264,779	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	3,960,251	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,261,814	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,385,462	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,521,889	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 1/16/2018 3:01 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,956,298	1,956,298	0	1,956,298	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER		86,509	86,509	0	86,509	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,585,049	2,585,049	0	2,585,049	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	312,899	10,974,959	11,287,858	-1,916,014	9,371,844	4.00
4.01	00401	COMMUNICATIONS	203,055	312,128	515,183	12,432	527,615	4.01
4.02	00402	DATA PROCESSING	749,896	779,130	1,529,026	76,690	1,605,716	4.02
4.03	00403	MATERIALS MANAGEMENT	270,264	44,861	315,125	10,583	325,708	4.03
4.04	00404	ADMITTING	605,150	21,848	626,998	29,791	656,789	4.04
4.05	00405	PATIENT ACCOUNTING	940,692	657,528	1,598,220	82,218	1,680,438	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	2,104,139	4,089,527	6,193,666	95,754	6,289,420	5.00
7.00	00700	OPERATION OF PLANT	653,588	2,078,766	2,732,354	31,979	2,764,333	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	122,994	73,396	196,390	5,121	201,511	8.00
9.00	00900	HOUSEKEEPING	650,679	117,059	767,738	42,234	809,972	9.00
10.00	01000	DIETARY	802,380	364,836	1,167,216	-718,390	448,826	10.00
11.00	01100	CAFETERIA	0	0	0	766,875	766,875	11.00
13.00	01300	NURSING ADMINISTRATION	1,499,038	205,063	1,704,101	114,784	1,818,885	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	82,725	98,805	181,530	6,667	188,197	14.00
15.00	01500	PHARMACY	474,185	2,883,485	3,357,670	49,301	3,406,971	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	560,309	269,755	830,064	36,862	866,926	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,049,423	1,161,736	5,211,159	-59,724	5,151,435	30.00
31.00	03100	INTENSIVE CARE UNIT	1,249,456	218,631	1,468,087	31,776	1,499,863	31.00
41.00	04100	SUBPROVIDER - IRF	733,427	139,034	872,461	-64,142	808,319	41.00
43.00	04300	NURSERY	0	0	0	278,012	278,012	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,954,775	631,190	2,585,965	190,794	2,776,759	50.00
53.00	05300	ANESTHESIOLOGY	0	35,136	35,136	25,000	60,136	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,075,349	839,621	2,914,970	139,886	3,054,856	54.00
60.00	06000	LABORATORY	1,520,292	2,030,626	3,550,918	74,978	3,625,896	60.00
65.00	06500	RESPIRATORY THERAPY	947,223	188,740	1,135,963	44,648	1,180,611	65.00
66.00	06600	PHYSICAL THERAPY	759,155	38,557	797,712	155,944	953,656	66.00
67.00	06700	OCCUPATIONAL THERAPY	232,634	1,275	233,909	14,883	248,792	67.00
68.00	06800	SPEECH PATHOLOGY	134,116	107	134,223	12,788	147,011	68.00
69.00	06900	ELECTROCARDIOLOGY	467,220	226,404	693,624	31,344	724,968	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	47,898	7,138	55,036	3,066	58,102	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,454,553	3,454,553	-1,554,733	1,899,820	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,554,733	1,554,733	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	135,650	76,643	212,293	3,856	216,149	76.00
76.97	07697	CARDIAC REHABILITATION	124,091	41,913	166,004	5,217	171,221	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	717,696	2,105,162	2,822,858	21,993	2,844,851	90.00
91.00	09100	EMERGENCY	1,886,320	317,313	2,203,633	86,700	2,290,333	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	680,123	158,922	839,045	38,244	877,289	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		15,650	15,650	0	15,650	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,746,841	39,287,353	67,034,194	-237,850	66,796,344	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	84,104	30,485	114,589	0	114,589	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,239,825	3,825,975	14,065,800	313,787	14,379,587	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	83,465	6,390	89,855	5,173	95,028	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	517,221	74,240	591,461	-95,437	496,024	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	752,872	752,872	0	752,872	193.03
194.00	07950	PARTNERSHIP HFC	27,708	4,690	32,398	0	32,398	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	48,000	48,000	0	48,000	194.03
194.04	07954	ATHLETIC TRAINERS	207,305	37,109	244,414	14,327	258,741	194.04
200.00		TOTAL (SUM OF LINES 118-199)	38,906,469	44,067,114	82,973,583	0	82,973,583	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 1/16/2018 3:01 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	83,386	2,039,684		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER	0	86,509		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	2,585,049		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-109,313	9,262,531		4.00
4.01	00401	COMMUNICATIONS	-30,660	496,955		4.01
4.02	00402	DATA PROCESSING	0	1,605,716		4.02
4.03	00403	MATERIALS MANAGEMENT	0	325,708		4.03
4.04	00404	ADMITTING	0	656,789		4.04
4.05	00405	PATIENT ACCOUNTING	-8,880	1,671,558		4.05
5.00	00500	ADMINISTRATIVE & GENERAL	-2,564,606	3,724,814		5.00
7.00	00700	OPERATION OF PLANT	-34,628	2,729,705		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	201,511		8.00
9.00	00900	HOUSEKEEPING	0	809,972		9.00
10.00	01000	DIETARY	-48	448,778		10.00
11.00	01100	CAFETERIA	-311,963	454,912		11.00
13.00	01300	NURSING ADMINISTRATION	-15,990	1,802,895		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	188,197		14.00
15.00	01500	PHARMACY	-788	3,406,183		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-26,456	840,470		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,395,109	3,756,326		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,499,863		31.00
41.00	04100	SUBPROVIDER - IRF	0	808,319		41.00
43.00	04300	NURSERY	0	278,012		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,776,759		50.00
53.00	05300	ANESTHESIOLOGY	0	60,136		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-137	3,054,719		54.00
60.00	06000	LABORATORY	0	3,625,896		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,180,611		65.00
66.00	06600	PHYSICAL THERAPY	0	953,656		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	248,792		67.00
68.00	06800	SPEECH PATHOLOGY	0	147,011		68.00
69.00	06900	ELECTROCARDIOLOGY	-57,391	667,577		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	58,102		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,899,820		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,554,733		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	ONCOLOGY	-61,250	154,899		76.00
76.97	07697	CARDIAC REHABILITATION	0	171,221		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-195,001	2,649,850		90.00
91.00	09100	EMERGENCY	0	2,290,333		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	877,289		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-15,650	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,744,484	62,051,860		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	114,589		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	14,379,587		192.00
192.01	19201	SOUTH CLINIC	0	0		192.01
192.02	19202	WEST CLINIC	0	0		192.02
192.03	19203	DIABETES CENTER	0	95,028		192.03
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	ADULT/CHILD CARE	0	496,024		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	752,872		193.03
194.00	07950	PARTNERSHIP HFC	0	32,398		194.00
194.01	07951	TRAFALGAR CLINIC	0	0		194.01
194.02	07952	EDINBURGH	0	0		194.02
194.03	07953	JAIL	0	48,000		194.03
194.04	07954	ATHLETIC TRAINERS	0	258,741		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-4,744,484	78,229,099		200.00

RECLASSIFICATIONS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 1/16/2018 3:01 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - NURSERY RECLASS					
1.00	NURSERY	43.00	226,326	51,686		1.00
	0		226,326	51,686		
	B - IMPLANTABLE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,554,733		1.00
	0		0	1,554,733		
	C - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	527,173	239,702		1.00
	0		527,173	239,702		
	D - DAY CARE RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	104,134	14,947		1.00
	0		104,134	14,947		
	F - PHYSICIAN RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	68,781	0		1.00
2.00	OPERATING ROOM	50.00	90,750	0		2.00
3.00	ANESTHESIOLOGY	53.00	25,000	0		3.00
	TOTALS		184,531	0		
	G - STD RECLASS					
1.00	DATA PROCESSING	4.02	0	2,212		1.00
2.00	PATIENT ACCOUNTING	4.05	0	7,233		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	1,166		3.00
4.00	NURSING ADMINISTRATION	13.00	0	1,888		4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	36,692		5.00
	TOTALS		0	49,191		
	H - EMPLOYEE WELLNESS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	66,984		1.00
	TOTALS		0	66,984		
	I - PTO RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	26,466	0		1.00
2.00	COMMUNICATIONS	4.01	12,432	0		2.00
3.00	DATA PROCESSING	4.02	76,690	0		3.00
4.00	MATERIALS MANAGEMENT	4.03	10,583	0		4.00
5.00	ADMITTING	4.04	29,791	0		5.00
6.00	PATIENT ACCOUNTING	4.05	82,218	0		6.00
7.00	ADMINISTRATIVE & GENERAL	5.00	162,738	0		7.00
8.00	OPERATION OF PLANT	7.00	31,979	0		8.00
9.00	LAUNDRY & LINEN SERVICE	8.00	5,121	0		9.00
10.00	HOUSEKEEPING	9.00	42,234	0		10.00
11.00	DIETARY	10.00	48,485	0		11.00
12.00	NURSING ADMINISTRATION	13.00	114,784	0		12.00
13.00	CENTRAL SERVICES & SUPPLY	14.00	6,667	0		13.00
14.00	PHARMACY	15.00	49,301	0		14.00
15.00	MEDICAL RECORDS & LIBRARY	16.00	36,862	0		15.00
16.00	ADULTS & PEDIATRICS	30.00	149,507	0		16.00
17.00	INTENSIVE CARE UNIT	31.00	31,776	0		17.00
18.00	SUBPROVIDER - IRF	41.00	45,418	0		18.00
19.00	OPERATING ROOM	50.00	100,044	0		19.00
20.00	RADIOLOGY-DIAGNOSTIC	54.00	139,886	0		20.00
21.00	LABORATORY	60.00	74,978	0		21.00
22.00	RESPIRATORY THERAPY	65.00	44,648	0		22.00
23.00	PHYSICAL THERAPY	66.00	46,384	0		23.00
24.00	OCCUPATIONAL THERAPY	67.00	14,883	0		24.00
25.00	SPEECH PATHOLOGY	68.00	12,788	0		25.00
26.00	ELECTROCARDIOLOGY	69.00	31,344	0		26.00
27.00	ELECTROENCEPHALOGRAPHY	70.00	3,066	0		27.00
28.00	ONCOLOGY	76.00	3,856	0		28.00
29.00	CARDIAC REHABILITATION	76.97	5,217	0		29.00
30.00	CLINIC	90.00	21,993	0		30.00
31.00	EMERGENCY	91.00	86,700	0		31.00
32.00	HOME HEALTH AGENCY	101.00	38,244	0		32.00
33.00	PHYSICIANS' PRIVATE OFFICES	192.00	498,318	0		33.00
34.00	DIABETES CENTER	192.03	5,173	0		34.00
35.00	ADULT/CHILD CARE	193.01	23,644	0		35.00
36.00	ATHLETIC TRAINERS	194.04	14,327	0		36.00
	TOTALS		2,128,545	0		
	J - PART A RECLASS					
1.00	PHYSICAL THERAPY	66.00	0	109,560		1.00
	TOTALS		0	109,560		
500.00	Grand Total: Increases		3,170,709	2,086,803		500.00

RECLASSIFICATIONS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 1/16/2018 3:01 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	226,326	51,686	0		1.00
	0		226,326	51,686			
	B - IMPLANTABLE RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,554,733	0		1.00
	0		0	1,554,733			
	C - CAFETERIA RECLASS						
1.00	DIETARY	10.00	527,173	239,702	0		1.00
	0		527,173	239,702			
	D - DAY CARE RECLASS						
1.00	ADULT/CHILD CARE	193.01	104,134	14,947	0		1.00
	0		104,134	14,947			
	F - PHYSICIAN RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	184,531	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		184,531	0			
	G - STD RECLASS						
1.00	DATA PROCESSING	4.02	2,212	0	0		1.00
2.00	PATIENT ACCOUNTING	4.05	7,233	0	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	1,166	0	0		3.00
4.00	NURSING ADMINISTRATION	13.00	1,888	0	0		4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	36,692	0	0		5.00
	TOTALS		49,191	0			
	H - EMPLOYEE WELLNESS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	66,984	0	0		1.00
	TOTALS		66,984	0			
	I - PTO RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,128,545	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
31.00		0.00	0	0	0		31.00
32.00		0.00	0	0	0		32.00
33.00		0.00	0	0	0		33.00
34.00		0.00	0	0	0		34.00
35.00		0.00	0	0	0		35.00
36.00		0.00	0	0	0		36.00
	TOTALS		0	2,128,545			
	J - PART A RECLASS						
1.00	SUBPROVIDER - IRF	41.00	0	109,560	0		1.00
	TOTALS		0	109,560			
500.00	Grand Total: Decreases		1,158,339	4,099,173			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 1/16/2018 3:01 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	4,743,329	0	0	0	0	1.00
2.00	Land Improvements	1,463,185	1,283,021	0	1,283,021	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	66,944,131	2,028,514	0	2,028,514	0	4.00
5.00	Fixed Equipment	12,824,093	106,346	0	106,346	0	5.00
6.00	Movable Equipment	37,840,030	12,639,983	0	12,639,983	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	123,814,768	16,057,864	0	16,057,864	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	123,814,768	16,057,864	0	16,057,864	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	4,743,329	0	1.00
2.00	Land Improvements	2,746,206	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	68,972,645	0	4.00
5.00	Fixed Equipment	12,930,439	0	5.00
6.00	Movable Equipment	50,480,013	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	139,872,632	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	139,872,632	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part II | Date/Time Prepared: 1/16/2018 3:01 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,956,298	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	86,509	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	2,585,049	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,627,856	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,956,298	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	86,509	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,585,049	2.00
3.00	Total (sum of lines 1-2)	0	4,627,856	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 1/16/2018 3:01 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	89,392,619	0	89,392,619	0.639100	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	50,480,013	0	50,480,013	0.360900	0	2.00
3.00	Total (sum of lines 1-2)	139,872,632	0	139,872,632	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,039,684	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	0	0	86,509	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,585,049	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,711,242	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	2,039,684	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	0	0	0	86,509	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,585,049	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	4,711,242	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 1/16/2018 3:01 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - TOWER (chapter 2)		0	CAP REL COSTS-BLDG & FIXT - TOWER	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,513,750			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - TOWER		0	CAP REL COSTS-BLDG & FIXT - TOWER	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 1/16/2018 3:01 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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	JMH PAIN CARE CENTER REVENUE OPERATI	B	-194,082	CLINIC	90.00	0	33.00
34.00	JMH NUTRIENT SERVICES DISCOUNTS OPER	B	6	DIETARY	10.00	0	34.00
35.00	JMH PURCHASE DISCOUNTS OPERATING FUN	B	-8,694	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	JMH SALE OF FILM	B	-137	RADIOLOGY-DIAGNOSTIC	54.00	0	36.00
37.00	JMH CAFETERIA REVENUE OPERATING FUND	B	-311,963	CAFETERIA	11.00	0	37.00
38.00	JMH CATERING REVENUE OPERATING FUND	B	-54	DIETARY	10.00	0	38.00
39.00	JMH MISCELLANEOUS PHARMACY REVENUE O	B	-788	PHARMACY	15.00	0	39.00
40.00	JMH RENT OF SPACE	B	-4,500	OPERATION OF PLANT	7.00	0	40.00
41.00	JMH MEDICAL RECORD FEES	B	-26,456	MEDICAL RECORDS & LIBRARY	16.00	0	41.00
42.00	JMH GENERAL ACCOUNT REVENUE OPERATIN	B	-6,662	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	JMH RETURNED CHECK FEES OPERATING FU	B	-375	ADMINISTRATIVE & GENERAL	5.00	0	43.00
45.01	BILLING SERVICES	B	-8,880	PATIENT ACCOUNTING	4.05	0	45.01
45.02	MISC REV	B	298	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	JMH PHJC PROGRAMS OTHER EXPENSE	B	5,354	ADMINISTRATIVE & GENERAL	5.00	9	45.03
45.04	1933 AHA LIFE	A	84,563	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.04
45.05	MEDICAL STAFF OTHER EXPENSES	A	149	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.06	CABLE SERVICES	A	-23,188	OPERATION OF PLANT	7.00	0	45.06
45.07	TELEPHONE SERVICES	A	-1,177	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.07
45.08	TELEPHONE SERVICES	A	-21,424	ADMINISTRATIVE & GENERAL	5.00	0	45.08
45.09	COMMUNICATIONS	A	-30,660	COMMUNICATIONS	4.01	0	45.09
45.10	ADVERTISING EXP - A&G	A	-235,547	ADMINISTRATIVE & GENERAL	5.00	0	45.10
45.11	ADVERTISING EXP - NURSING ADMIN	A	-15,990	NURSING ADMINISTRATION	13.00	0	45.11
45.13	ADVERTISING EXP - WOUND CARE	A	-919	CLINIC	90.00	0	45.13
45.14	DAYCARE	B	-119,080	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.14
45.15	LOBBYING EXPENSE - AHA	A	-4,901	ADMINISTRATIVE & GENERAL	5.00	0	45.15
45.16	LOBBYING EXPENSE - IHHA	A	-1,628	ADMINISTRATIVE & GENERAL	5.00	0	45.16
45.17	PROF - BUILDING	A	-6,940	OPERATION OF PLANT	7.00	0	45.17
45.18	PROF - BUILDING	A	-1,525	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.18
45.19	INTEREST INCOME	B	-15,650	INTEREST EXPENSE	113.00	0	45.19
45.20	HAF EXPENSE	A	-2,291,176	ADMINISTRATIVE & GENERAL	5.00	0	45.20
45.21	DAYCARE DISCOUNT	A	11,292	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.21
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,744,484				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 1/16/2018 3:01 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	1,395,109	1,395,109	0	0	0	1.00
2.00	60.00	LABORATORY	110,004	0	110,004	211,500	1,575	2.00
3.00	69.00	ELECTROCARDIOLOGY	57,391	57,391	0	0	0	3.00
4.00	76.00	ONCOLOGY	61,250	61,250	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,623,754	1,513,750	110,004		1,575	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	160,150	8,008	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	76.00	ONCOLOGY	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			160,150	8,008	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	1,395,109		1.00
2.00	60.00	LABORATORY	0	160,150	0	0		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	57,391		3.00
4.00	76.00	ONCOLOGY	0	0	0	61,250		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	160,150	0	1,513,750		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 1/16/2018 3:01 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	BLDG & FIXT - TOWER	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,039,684	2,039,684				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER	86,509	0	86,509			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,585,049			2,585,049		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,262,531	21,767	0	1,151	9,285,449	4.00
4.01	00401	COMMUNICATIONS	496,955	2,867	0	0	49,435	4.01
4.02	00402	DATA PROCESSING	1,605,716	45,664	0	1,211,900	189,120	4.02
4.03	00403	MATERIALS MANAGEMENT	325,708	27,909	0	5,741	64,429	4.03
4.04	00404	ADMITTING	656,789	16,333	1,842	0	145,662	4.04
4.05	00405	PATIENT ACCOUNTING	1,671,558	48,509	0	10,134	233,006	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	3,724,814	69,488	0	25,435	504,410	5.00
7.00	00700	OPERATION OF PLANT	2,729,705	182,073	12,498	39,014	157,276	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	201,511	17,536	0	4,296	29,391	8.00
9.00	00900	HOUSEKEEPING	809,972	13,619	937	3,865	158,961	9.00
10.00	01000	DIETARY	448,778	28,573	554	17,992	74,258	10.00
11.00	01100	CAFETERIA	454,912	30,426	0	0	120,939	11.00
13.00	01300	NURSING ADMINISTRATION	1,802,895	71,976	0	28,359	369,794	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	188,197	12,394	0	28,604	20,507	14.00
15.00	01500	PHARMACY	3,406,183	14,925	0	4,835	120,093	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	840,470	28,296	0	6,986	136,997	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,756,326	201,163	19,566	112,938	927,134	30.00
31.00	03100	INTENSIVE CARE UNIT	1,499,863	57,525	8,861	30,856	293,927	31.00
41.00	04100	SUBPROVIDER - IRF	808,319	49,333	7,599	17,003	178,675	41.00
43.00	04300	NURSERY	278,012	4,559	0	0	51,921	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,776,759	333,810	802	386,374	492,215	50.00
53.00	05300	ANESTHESIOLOGY	60,136	2,874	0	12,303	5,735	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,054,719	120,594	12,062	297,737	508,197	54.00
60.00	06000	LABORATORY	3,625,896	58,714	6,924	122,412	365,971	60.00
65.00	06500	RESPIRATORY THERAPY	1,180,611	24,612	1,203	13,422	227,545	65.00
66.00	06600	PHYSICAL THERAPY	953,656	46,233	0	8,754	184,799	66.00
67.00	06700	OCCUPATIONAL THERAPY	248,792	9,738	0	2,069	56,783	67.00
68.00	06800	SPEECH PATHOLOGY	147,011	605	93	324	33,701	68.00
69.00	06900	ELECTROCARDIOLOGY	667,577	7,878	99	29,422	114,376	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	58,102	1,328	204	1,603	11,692	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,899,820	0	0	12,162	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,554,733	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	154,899	51,055	0	1,875	32,004	76.00
76.97	07697	CARDIAC REHABILITATION	171,221	18,317	0	8,953	29,665	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,649,850	84,004	496	14,318	169,692	90.00
91.00	09100	EMERGENCY	2,290,333	72,464	10,860	26,955	452,631	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	877,289	9,519	0	56	164,801	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	62,051,860	1,786,680	84,600	2,487,848	6,675,742	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	114,589	9,461	1,457	3,868	19,294	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,379,587	189,112	0	92,862	2,412,688	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	95,028	2,932	452	471	20,334	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	496,024	35,247	0	0	100,190	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	752,872	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	32,398	16,252	0	0	6,356	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	48,000	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	258,741	0	0	0	50,845	194.04
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)	78,229,099	2,039,684	86,509	2,585,049	9,285,449	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 1/16/2018 3:01 pm

		Cost Center Description	COMMUNICATIONS	DATA PROCESSING	MATERIALS MANAGEMENT	ADMITTING	PATIENT ACCOUNTING	
			4.01	4.02	4.03	4.04	4.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS	549,257					4.01
4.02	00402	DATA PROCESSING	56,174	3,108,574				4.02
4.03	00403	MATERIALS MANAGEMENT	12,067	42,233	478,087			4.03
4.04	00404	ADMITTING	11,651	115,180	1,153	948,610		4.04
4.05	00405	PATIENT ACCOUNTING	36,617	339,142	2,251	0	2,341,217	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	32,040	336,581	6,174	0	0	5.00
7.00	00700	OPERATION OF PLANT	16,228	26,875	247	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,081	20,476	1,073	0	0	8.00
9.00	00900	HOUSEKEEPING	5,825	0	6,038	0	0	9.00
10.00	01000	DIETARY	10,403	90,864	14,193	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	17,892	110,061	3,645	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	3,526	0	0	14.00
15.00	01500	PHARMACY	7,906	30,715	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,060	140,775	83	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,691	226,520	13,611	52,593	129,796	30.00
31.00	03100	INTENSIVE CARE UNIT	11,651	78,066	4,174	9,457	23,338	31.00
41.00	04100	SUBPROVIDER - IRF	7,490	58,870	1,010	8,797	21,710	41.00
43.00	04300	NURSERY	0	0	0	3,200	7,898	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	34,537	264,913	22,264	146,884	362,498	50.00
53.00	05300	ANESTHESIOLOGY	0	0	167	16,533	40,803	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,637	191,966	16,016	180,074	444,539	54.00
60.00	06000	LABORATORY	28,295	140,775	66,799	132,861	327,889	60.00
65.00	06500	RESPIRATORY THERAPY	7,490	75,507	6,542	27,519	67,914	65.00
66.00	06600	PHYSICAL THERAPY	8,738	19,197	1,214	15,897	39,233	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,664	6,399	1	9,788	24,155	67.00
68.00	06800	SPEECH PATHOLOGY	1,664	3,839	5	3,113	7,683	68.00
69.00	06900	ELECTROCARDIOLOGY	17,892	122,858	3,941	25,858	63,815	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	832	3,839	63	735	1,813	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	197,761	32,277	79,658	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	22,099	54,538	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	51,227	126,423	73.00
76.00	03020	ONCOLOGY	15,396	21,756	0	1,058	2,611	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	451	2,569	6,340	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,322	102,382	28,395	53,071	130,974	90.00
91.00	09100	EMERGENCY	23,718	154,853	5,903	93,412	230,532	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	9,570	57,590	688	7,460	18,410	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	468,531	2,782,232	407,388	896,482	2,212,570	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,242	20,476	864	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	63,665	244,437	64,521	52,128	128,647	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	1,248	3,839	10	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	6,242	26,875	4,164	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	1,079	0	0	193.03
194.00	07950	PARTNERSHIP HFC	3,329	30,715	57	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	4	0	0	194.04
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)	549,257	3,108,574	478,087	948,610	2,341,217	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 1/16/2018 3:01 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A.05	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL	4,698,942	4,698,942				5.00
7.00	00700	OPERATION OF PLANT	3,163,916	202,190	3,366,106			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	276,364	17,661	36,324	330,349		8.00
9.00	00900	HOUSEKEEPING	999,217	63,855	28,210	59,083	1,150,365	9.00
10.00	01000	DIETARY	685,615	43,814	59,185	5,429	20,622	10.00
11.00	01100	CAFETERIA	606,277	38,744	63,023	0	21,959	11.00
13.00	01300	NURSING ADMINISTRATION	2,404,622	153,667	149,087	0	51,946	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	253,228	16,183	25,671	0	8,945	14.00
15.00	01500	PHARMACY	3,584,657	229,078	30,914	0	10,771	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,170,667	74,811	58,610	0	20,422	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,483,338	350,413	416,680	85,364	145,184	30.00
31.00	03100	INTENSIVE CARE UNIT	2,017,718	128,942	119,155	20,692	41,517	31.00
41.00	04100	SUBPROVIDER - IRF	1,158,806	74,053	102,187	14,909	35,605	41.00
43.00	04300	NURSERY	345,590	22,085	9,444	0	3,290	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,821,056	308,090	691,436	66,177	240,918	50.00
53.00	05300	ANESTHESIOLOGY	138,551	8,854	5,953	0	2,074	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,847,541	309,782	249,793	21,375	87,035	54.00
60.00	06000	LABORATORY	4,876,536	311,635	121,618	0	42,375	60.00
65.00	06500	RESPIRATORY THERAPY	1,632,365	104,316	50,980	0	17,763	65.00
66.00	06600	PHYSICAL THERAPY	1,277,721	81,653	95,765	1,579	33,367	66.00
67.00	06700	OCCUPATIONAL THERAPY	359,389	22,967	20,171	0	7,028	67.00
68.00	06800	SPEECH PATHOLOGY	198,038	12,656	1,254	0	437	68.00
69.00	06900	ELECTROCARDIOLOGY	1,053,716	67,338	16,318	2,354	5,686	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	80,211	5,126	2,750	0	958	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,221,678	141,976	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,631,370	104,253	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	177,650	11,353	0	0	0	73.00
76.00	03020	ONCOLOGY	280,654	17,935	105,753	0	36,847	76.00
76.97	07697	CARDIAC REHABILITATION	237,516	15,178	37,940	0	13,220	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,241,504	207,148	174,003	1,799	60,628	90.00
91.00	09100	EMERGENCY	3,361,661	214,827	150,100	47,791	52,299	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,145,383	73,196	19,718	0	6,870	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	58,431,497	3,433,779	2,842,042	326,552	967,766	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	176,251	11,263	19,597	0	6,828	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,627,647	1,126,494	391,719	3,797	136,486	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	124,314	7,944	6,074	0	2,116	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	668,742	42,736	73,010	0	25,439	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	753,951	48,181	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	89,107	5,694	33,664	0	11,730	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	48,000	3,067	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	309,590	19,784	0	0	0	194.04
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)	78,229,099	4,698,942	3,366,106	330,349	1,150,365	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 1/16/2018 3:01 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	814,665					10.00
11.00	01100	CAFETERIA	0	730,003				11.00
13.00	01300	NURSING ADMINISTRATION	0	22,604	2,781,926			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,757	41,488	349,272		14.00
15.00	01500	PHARMACY	0	13,749	0	0	3,869,169	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,801	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	556,798	93,760	1,035,253	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	108,247	31,698	349,996	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	149,620	18,063	199,448	0	0	41.00
43.00	04300	NURSERY	0	5,642	62,302	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	50,656	559,322	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	217	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	56,711	0	0	0	54.00
60.00	06000	LABORATORY	0	57,372	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	24,543	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	20,950	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,577	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,227	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,135	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,494	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	349,272	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,869,169	73.00
76.00	03020	ONCOLOGY	0	4,062	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	3,222	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	25,084	0	0	0	90.00
91.00	09100	EMERGENCY	0	48,373	534,117	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	17,828	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	814,665	549,525	2,781,926	349,272	3,869,169	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,659	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	123,977	0	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	2,127	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	39,966	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	1,283	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	8,466	0	0	0	194.04
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)	814,665	730,003	2,781,926	349,272	3,869,169	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 1/16/2018 3:01 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,354,311					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	75,082	8,241,872	0	8,241,872		30.00
31.00	03100	INTENSIVE CARE UNIT	13,500	2,831,465	0	2,831,465		31.00
41.00	04100	SUBPROVIDER - IRF	12,558	1,765,249	0	1,765,249		41.00
43.00	04300	NURSERY	4,569	452,922	0	452,922		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	209,692	6,947,347	0	6,947,347		50.00
53.00	05300	ANESTHESIOLOGY	23,603	179,252	0	179,252		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	257,147	5,829,384	0	5,829,384		54.00
60.00	06000	LABORATORY	189,673	5,599,209	0	5,599,209		60.00
65.00	06500	RESPIRATORY THERAPY	39,286	1,869,253	0	1,869,253		65.00
66.00	06600	PHYSICAL THERAPY	22,695	1,533,730	0	1,533,730		66.00
67.00	06700	OCCUPATIONAL THERAPY	13,973	429,105	0	429,105		67.00
68.00	06800	SPEECH PATHOLOGY	4,444	220,056	0	220,056		68.00
69.00	06900	ELECTROCARDIOLOGY	36,915	1,193,462	0	1,193,462		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,049	91,588	0	91,588		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	46,079	2,759,005	0	2,759,005		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	31,549	1,767,172	0	1,767,172		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73,132	4,131,304	0	4,131,304		73.00
76.00	03020	ONCOLOGY	1,510	446,761	0	446,761		76.00
76.97	07697	CARDIAC REHABILITATION	3,668	310,744	0	310,744		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	75,764	3,785,930	0	3,785,930		90.00
91.00	09100	EMERGENCY	133,355	4,542,523	0	4,542,523		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	10,650	1,273,645	0	1,273,645		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,279,893	56,200,978	0	56,200,978		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	218,598	0	218,598		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	74,418	19,484,538	0	19,484,538		192.00
192.01	19201	SOUTH CLINIC	0	0	0	0		192.01
192.02	19202	WEST CLINIC	0	0	0	0		192.02
192.03	19203	DIABETES CENTER	0	142,575	0	142,575		192.03
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	ADULT/CHILD CARE	0	849,893	0	849,893		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	802,132	0	802,132		193.03
194.00	07950	PARTNERSHIP HFC	0	141,478	0	141,478		194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0		194.01
194.02	07952	EDINBURGH	0	0	0	0		194.02
194.03	07953	JAIL	0	51,067	0	51,067		194.03
194.04	07954	ATHLETIC TRAINERS	0	337,840	0	337,840		194.04
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	1,354,311	78,229,099	0	78,229,099		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 1/16/2018 3:01 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	BLDG & FIXT - TOWER	MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	21,767	0	1,151	22,918	4.00
4.01	00401	COMMUNICATIONS	0	2,867	0	0	2,867	4.01
4.02	00402	DATA PROCESSING	0	45,664	0	1,211,900	1,257,564	4.02
4.03	00403	MATERIALS MANAGEMENT	0	27,909	0	5,741	33,650	4.03
4.04	00404	ADMITTING	0	16,333	1,842	0	18,175	4.04
4.05	00405	PATIENT ACCOUNTING	0	48,509	0	10,134	58,643	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	0	69,488	0	25,435	94,923	5.00
7.00	00700	OPERATION OF PLANT	0	182,073	12,498	39,014	233,585	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	17,536	0	4,296	21,832	8.00
9.00	00900	HOUSEKEEPING	0	13,619	937	3,865	18,421	9.00
10.00	01000	DIETARY	0	28,573	554	17,992	47,119	10.00
11.00	01100	CAFETERIA	0	30,426	0	0	30,426	11.00
13.00	01300	NURSING ADMINISTRATION	0	71,976	0	28,359	100,335	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,394	0	28,604	40,998	14.00
15.00	01500	PHARMACY	0	14,925	0	4,835	19,760	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,296	0	6,986	35,282	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	201,163	19,566	112,938	333,667	30.00
31.00	03100	INTENSIVE CARE UNIT	0	57,525	8,861	30,856	97,242	31.00
41.00	04100	SUBPROVIDER - IRF	0	49,333	7,599	17,003	73,935	41.00
43.00	04300	NURSERY	0	4,559	0	0	4,559	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	333,810	802	386,374	720,986	50.00
53.00	05300	ANESTHESIOLOGY	0	2,874	0	12,303	15,177	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	120,594	12,062	297,737	430,393	54.00
60.00	06000	LABORATORY	0	58,714	6,924	122,412	188,050	60.00
65.00	06500	RESPIRATORY THERAPY	0	24,612	1,203	13,422	39,237	65.00
66.00	06600	PHYSICAL THERAPY	0	46,233	0	8,754	54,987	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,738	0	2,069	11,807	67.00
68.00	06800	SPEECH PATHOLOGY	0	605	93	324	1,022	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,878	99	29,422	37,399	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,328	204	1,603	3,135	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	12,162	12,162	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	51,055	0	1,875	52,930	76.00
76.97	07697	CARDIAC REHABILITATION	0	18,317	0	8,953	27,270	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	84,004	496	14,318	98,818	90.00
91.00	09100	EMERGENCY	0	72,464	10,860	26,955	110,279	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	9,519	0	56	9,575	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,786,680	84,600	2,487,848	4,359,128	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,461	1,457	3,868	14,786	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	189,112	0	92,862	281,974	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	2,932	452	471	3,855	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	35,247	0	0	35,247	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	16,252	0	0	16,252	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	2,039,684	86,509	2,585,049	4,711,242	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 1/16/2018 3:01 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	DATA PROCESSING	MATERIALS MANAGEMENT	ADMITTING	
			4.00	4.01	4.02	4.03	4.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	22,918					4.00
4.01	00401	COMMUNICATIONS	122	2,989				4.01
4.02	00402	DATA PROCESSING	467	306	1,258,337			4.02
4.03	00403	MATERIALS MANAGEMENT	159	66	17,096	50,971		4.03
4.04	00404	ADMITTING	359	63	46,624	123	65,344	4.04
4.05	00405	PATIENT ACCOUNTING	575	199	137,283	240	0	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	1,244	174	136,246	658	0	5.00
7.00	00700	OPERATION OF PLANT	388	88	10,879	26	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	73	11	8,289	114	0	8.00
9.00	00900	HOUSEKEEPING	392	32	0	644	0	9.00
10.00	01000	DIETARY	183	57	36,781	1,513	0	10.00
11.00	01100	CAFETERIA	298	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	912	97	44,552	389	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	51	0	0	376	0	14.00
15.00	01500	PHARMACY	296	43	12,433	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	338	93	56,985	9	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,287	238	91,694	1,451	3,619	30.00
31.00	03100	INTENSIVE CARE UNIT	725	63	31,601	445	651	31.00
41.00	04100	SUBPROVIDER - IRF	441	41	23,830	108	605	41.00
43.00	04300	NURSERY	128	0	0	0	220	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,214	188	107,236	2,374	10,106	50.00
53.00	05300	ANESTHESIOLOGY	14	0	0	18	1,138	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,254	118	77,707	1,708	12,463	54.00
60.00	06000	LABORATORY	903	154	56,985	7,122	9,142	60.00
65.00	06500	RESPIRATORY THERAPY	561	41	30,565	698	1,893	65.00
66.00	06600	PHYSICAL THERAPY	456	48	7,771	129	1,094	66.00
67.00	06700	OCCUPATIONAL THERAPY	140	9	2,590	0	673	67.00
68.00	06800	SPEECH PATHOLOGY	83	9	1,554	0	214	68.00
69.00	06900	ELECTROCARDIOLOGY	282	97	49,733	420	1,779	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29	5	1,554	7	51	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	21,084	2,221	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,521	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,525	73.00
76.00	03020	ONCOLOGY	79	84	8,807	0	73	76.00
76.97	07697	CARDIAC REHABILITATION	73	0	0	48	177	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	419	45	41,444	3,028	3,652	90.00
91.00	09100	EMERGENCY	1,117	129	62,684	629	6,427	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	407	52	23,312	73	513	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,469	2,550	1,126,235	43,434	61,757	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	48	34	8,289	92	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,963	346	98,947	6,879	3,587	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	50	7	1,554	1	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	247	34	10,879	444	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	115	0	193.03
194.00	07950	PARTNERSHIP HFC	16	18	12,433	6	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	125	0	0	0	0	194.04
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)	22,918	2,989	1,258,337	50,971	65,344	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 1/16/2018 3:01 pm

		Cost Center Description	PATIENT ACCOUNTING	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.05	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING	196,940					4.05
5.00	00500	ADMINISTRATIVE & GENERAL	0	233,245				5.00
7.00	00700	OPERATION OF PLANT	0	10,036	255,002			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	877	2,752	33,948		8.00
9.00	00900	HOUSEKEEPING	0	3,170	2,137	6,072	30,868	9.00
10.00	01000	DIETARY	0	2,175	4,484	558	553	10.00
11.00	01100	CAFETERIA	0	1,923	4,774	0	589	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,627	11,294	0	1,394	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	803	1,945	0	240	14.00
15.00	01500	PHARMACY	0	11,371	2,342	0	289	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,713	4,440	0	548	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,923	17,393	31,566	8,772	3,896	30.00
31.00	03100	INTENSIVE CARE UNIT	1,964	6,400	9,027	2,126	1,114	31.00
41.00	04100	SUBPROVIDER - IRF	1,827	3,676	7,741	1,532	955	41.00
43.00	04300	NURSERY	665	1,096	715	0	88	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,505	15,292	52,381	6,801	6,464	50.00
53.00	05300	ANESTHESIOLOGY	3,434	439	451	0	56	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,326	15,376	18,923	2,197	2,335	54.00
60.00	06000	LABORATORY	27,593	15,468	9,213	0	1,137	60.00
65.00	06500	RESPIRATORY THERAPY	5,715	5,178	3,862	0	477	65.00
66.00	06600	PHYSICAL THERAPY	3,302	4,053	7,255	162	895	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,033	1,140	1,528	0	189	67.00
68.00	06800	SPEECH PATHOLOGY	647	628	95	0	12	68.00
69.00	06900	ELECTROCARDIOLOGY	5,370	3,342	1,236	242	153	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	153	254	208	0	26	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,703	7,047	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,590	5,175	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,639	564	0	0	0	73.00
76.00	03020	ONCOLOGY	220	890	8,011	0	989	76.00
76.97	07697	CARDIAC REHABILITATION	534	753	2,874	0	355	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,022	10,282	13,182	185	1,627	90.00
91.00	09100	EMERGENCY	19,400	10,663	11,371	4,911	1,403	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,549	3,633	1,494	0	184	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	186,114	170,437	215,301	33,558	25,968	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	559	1,485	0	183	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,826	55,925	29,675	390	3,662	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	394	460	0	57	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	2,121	5,531	0	683	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	2,392	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	283	2,550	0	315	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	152	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	982	0	0	0	194.04
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)	196,940	233,245	255,002	33,948	30,868	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 1/16/2018 3:01 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	93,423					10.00
11.00	01100	CAFETERIA	0	38,010				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,177	167,777			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	196	2,502	47,111		14.00
15.00	01500	PHARMACY	0	716	0	0	47,250	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,552	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	63,852	4,882	62,436	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	12,413	1,650	21,108	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	17,158	941	12,029	0	0	41.00
43.00	04300	NURSERY	0	294	3,757	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,638	33,733	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	11	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,953	0	0	0	54.00
60.00	06000	LABORATORY	0	2,987	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,278	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,091	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	290	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	168	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	580	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	78	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	47,111	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	47,250	73.00
76.00	03020	ONCOLOGY	0	212	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	168	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,306	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,519	32,212	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	928	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	93,423	28,615	167,777	47,111	47,250	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	243	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,452	0	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	111	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	2,081	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	67	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	441	0	0	0	194.04
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)	93,423	38,010	167,777	47,111	47,250	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 1/16/2018 3:01 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	102,960					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,706	642,382	0	642,382		30.00
31.00	03100	INTENSIVE CARE UNIT	1,026	187,555	0	187,555		31.00
41.00	04100	SUBPROVIDER - IRF	954	145,773	0	145,773		41.00
43.00	04300	NURSERY	347	11,869	0	11,869		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,935	1,005,853	0	1,005,853		50.00
53.00	05300	ANESTHESIOLOGY	1,794	22,532	0	22,532		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,585	622,338	0	622,338		54.00
60.00	06000	LABORATORY	14,413	333,167	0	333,167		60.00
65.00	06500	RESPIRATORY THERAPY	2,985	92,490	0	92,490		65.00
66.00	06600	PHYSICAL THERAPY	1,725	82,968	0	82,968		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,062	21,461	0	21,461		67.00
68.00	06800	SPEECH PATHOLOGY	338	4,770	0	4,770		68.00
69.00	06900	ELECTROCARDIOLOGY	2,805	103,438	0	103,438		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	80	5,580	0	5,580		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,502	99,830	0	99,830		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,397	13,683	0	13,683		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,557	67,535	0	67,535		73.00
76.00	03020	ONCOLOGY	115	72,410	0	72,410		76.00
76.97	07697	CARDIAC REHABILITATION	279	32,531	0	32,531		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,757	190,767	0	190,767		90.00
91.00	09100	EMERGENCY	10,134	273,878	0	273,878		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	809	42,529	0	42,529		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	97,305	4,075,339	0	4,075,339		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25,719	0	25,719		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,655	510,281	0	510,281		192.00
192.01	19201	SOUTH CLINIC	0	0	0	0		192.01
192.02	19202	WEST CLINIC	0	0	0	0		192.02
192.03	19203	DIABETES CENTER	0	6,489	0	6,489		192.03
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	ADULT/CHILD CARE	0	57,267	0	57,267		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	2,507	0	2,507		193.03
194.00	07950	PARTNERSHIP HFC	0	31,940	0	31,940		194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0		194.01
194.02	07952	EDINBURGH	0	0	0	0		194.02
194.03	07953	JAIL	0	152	0	152		194.03
194.04	07954	ATHLETIC TRAINERS	0	1,548	0	1,548		194.04
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	102,960	4,711,242	0	4,711,242		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 1/16/2018 3:01 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (TOTAL FEET)	BLDG & FIXT - TOWER (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	
			1.00	1.01	2.00	4.00	4.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	279,616					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER	0	76,991				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2,575,452			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,984	0	1,147	40,475,340		4.00
4.01	00401	COMMUNICATIONS	393	0	0	215,487	1,320	4.01
4.02	00402	DATA PROCESSING	6,260	0	1,207,398	824,374	135	4.02
4.03	00403	MATERIALS MANAGEMENT	3,826	0	5,720	280,847	29	4.03
4.04	00404	ADMITTING	2,239	1,639	0	634,941	28	4.04
4.05	00405	PATIENT ACCOUNTING	6,650	0	10,096	1,015,677	88	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	9,526	0	25,341	2,198,727	77	5.00
7.00	00700	OPERATION OF PLANT	24,960	11,123	38,869	685,567	39	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,404	0	4,280	128,115	5	8.00
9.00	00900	HOUSEKEEPING	1,867	834	3,851	692,913	14	9.00
10.00	01000	DIETARY	3,917	493	17,925	323,692	25	10.00
11.00	01100	CAFETERIA	4,171	0	0	527,173	0	11.00
13.00	01300	NURSING ADMINISTRATION	9,867	0	28,254	1,611,934	43	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,699	0	28,498	89,392	0	14.00
15.00	01500	PHARMACY	2,046	0	4,817	523,486	19	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,879	0	6,960	597,171	41	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,577	17,413	112,519	4,041,385	105	30.00
31.00	03100	INTENSIVE CARE UNIT	7,886	7,886	30,741	1,281,232	28	31.00
41.00	04100	SUBPROVIDER - IRF	6,763	6,763	16,940	778,845	18	41.00
43.00	04300	NURSERY	625	0	0	226,326	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,761	714	384,940	2,145,569	83	50.00
53.00	05300	ANESTHESIOLOGY	394	0	12,257	25,000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,532	10,735	296,632	2,215,235	52	54.00
60.00	06000	LABORATORY	8,049	6,162	121,958	1,595,270	68	60.00
65.00	06500	RESPIRATORY THERAPY	3,374	1,071	13,372	991,871	18	65.00
66.00	06600	PHYSICAL THERAPY	6,338	0	8,722	805,539	21	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,335	0	2,061	247,517	4	67.00
68.00	06800	SPEECH PATHOLOGY	83	83	323	146,904	4	68.00
69.00	06900	ELECTROCARDIOLOGY	1,080	88	29,313	498,564	43	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	182	182	1,597	50,964	2	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	12,117	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	6,999	0	1,868	139,506	37	76.00
76.97	07697	CARDIAC REHABILITATION	2,511	0	8,920	129,308	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,516	441	14,265	739,689	20	90.00
91.00	09100	EMERGENCY	9,934	9,665	26,855	1,973,020	57	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,305	0	56	718,367	23	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	244,932	75,292	2,478,612	29,099,607	1,126	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,297	1,297	3,854	84,104	15	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	25,925	0	92,517	10,516,920	153	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	402	402	469	88,638	3	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	4,832	0	0	436,731	15	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	2,228	0	0	27,708	8	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	221,632	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,039,684	86,509	2,585,049	9,285,449	549,257	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 1/16/2018 3:01 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (TOTAL FEET)	BLDG & FIXT - TOWER (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	
			1.00	1.01	2.00	4.00	4.01	
203.00		Unit cost multiplier (Wkst. B, Part I)	7.294590	1.123625	1.003726	0.229410	416.103788	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				22,918	2,989	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000566	2.264394	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 1/16/2018 3:01 pm

		Cost Center Description	DATA PROCESSING (WORK ORDERS)	MATERIALS MANAGEMENT (SUPPLY USAGE)	ADMITTING (GROSS REVENUE)	PATIENT ACCOUNTING (GROSS REVENUE)	Reconciliation	
			4.02	4.03	4.04	4.05	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING	2,429					4.02
4.03	00403	MATERIALS MANAGEMENT	33	8,280,362				4.03
4.04	00404	ADMITTING	90	19,966	200,227,357			4.04
4.05	00405	PATIENT ACCOUNTING	265	38,987	0	200,227,357		4.05
5.00	00500	ADMINISTRATIVE & GENERAL	263	106,935	0	0	-4,698,942	5.00
7.00	00700	OPERATION OF PLANT	21	4,284	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16	18,582	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	104,585	0	0	0	9.00
10.00	01000	DIETARY	71	245,830	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	86	63,123	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	61,074	0	0	0	14.00
15.00	01500	PHARMACY	24	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	110	1,431	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	177	235,743	11,100,282	11,100,282	0	30.00
31.00	03100	INTENSIVE CARE UNIT	61	72,290	1,995,911	1,995,911	0	31.00
41.00	04100	SUBPROVIDER - IRF	46	17,490	1,856,636	1,856,636	0	41.00
43.00	04300	NURSERY	0	0	675,431	675,431	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	207	385,611	31,001,255	31,001,255	0	50.00
53.00	05300	ANESTHESIOLOGY	0	2,900	3,489,516	3,489,516	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	150	277,403	38,020,982	38,020,982	0	54.00
60.00	06000	LABORATORY	110	1,156,946	28,041,519	28,041,519	0	60.00
65.00	06500	RESPIRATORY THERAPY	59	113,309	5,808,115	5,808,115	0	65.00
66.00	06600	PHYSICAL THERAPY	15	21,026	3,355,255	3,355,255	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5	12	2,065,797	2,065,797	0	67.00
68.00	06800	SPEECH PATHOLOGY	3	78	657,049	657,049	0	68.00
69.00	06900	ELECTROCARDIOLOGY	96	68,257	5,457,512	5,457,512	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3	1,086	155,063	155,063	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,425,123	6,812,458	6,812,458	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	4,664,200	4,664,200	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	10,811,878	10,811,878	0	73.00
76.00	03020	ONCOLOGY	17	0	223,288	223,288	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	7,817	542,217	542,217	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	80	491,803	11,201,072	11,201,072	0	90.00
91.00	09100	EMERGENCY	121	102,236	19,715,418	19,715,418	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	45	11,913	1,574,485	1,574,485	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,174	7,055,840	189,225,339	189,225,339	-4,698,942	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16	14,964	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	191	1,117,498	11,002,018	11,002,018	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	3	175	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	21	72,122	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	18,696	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	24	994	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	73	0	0	0	194.04
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)	3,108,574	478,087	948,610	2,341,217		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,279.775216	0.057737	0.004738	0.011693		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,258,337	50,971	65,344	196,940		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 1/16/2018 3:01 pm

Cost Center Description			DATA PROCESSING (WORK ORDERS)	MATERIALS MANAGEMENT (SUPPLY USAGE)	ADMITTING (GROSS REVENUE)	PATIENT ACCOUNTING (GROSS REVENUE)	Reconciliation	
			4.02	4.03	4.04	4.05	5A	
205.00		Unit cost multiplier (Wkst. B, Part II)	518.047345	0.006156	0.000326	0.000984		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 1/16/2018 3:01 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (TOTAL FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TOTAL FEET)	DIETARY (MEALS SERVED)	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL	73,530,157					5.00
7.00	00700	OPERATION OF PLANT	3,163,916	222,778				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	276,364	2,404	503,873			8.00
9.00	00900	HOUSEKEEPING	999,217	1,867	90,117	218,507		9.00
10.00	01000	DIETARY	685,615	3,917	8,281	3,917	7,955	10.00
11.00	01100	CAFETERIA	606,277	4,171	0	4,171	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,404,622	9,867	0	9,867	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	253,228	1,699	0	1,699	0	14.00
15.00	01500	PHARMACY	3,584,657	2,046	0	2,046	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,170,667	3,879	0	3,879	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,483,338	27,577	130,204	27,577	5,437	30.00
31.00	03100	INTENSIVE CARE UNIT	2,017,718	7,886	31,561	7,886	1,057	31.00
41.00	04100	SUBPROVIDER - IRF	1,158,806	6,763	22,740	6,763	1,461	41.00
43.00	04300	NURSERY	345,590	625	0	625	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,821,056	45,761	100,938	45,761	0	50.00
53.00	05300	ANESTHESIOLOGY	138,551	394	0	394	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,847,541	16,532	32,603	16,532	0	54.00
60.00	06000	LABORATORY	4,876,536	8,049	0	8,049	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,632,365	3,374	0	3,374	0	65.00
66.00	06600	PHYSICAL THERAPY	1,277,721	6,338	2,408	6,338	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	359,389	1,335	0	1,335	0	67.00
68.00	06800	SPEECH PATHOLOGY	198,038	83	0	83	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,053,716	1,080	3,590	1,080	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	80,211	182	0	182	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,221,678	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,631,370	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	177,650	0	0	0	0	73.00
76.00	03020	ONCOLOGY	280,654	6,999	0	6,999	0	76.00
76.97	07697	CARDIAC REHABILITATION	237,516	2,511	0	2,511	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,241,504	11,516	2,744	11,516	0	90.00
91.00	09100	EMERGENCY	3,361,661	9,934	72,895	9,934	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,145,383	1,305	0	1,305	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	53,732,555	188,094	498,081	183,823	7,955	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	176,251	1,297	0	1,297	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,627,647	25,925	5,792	25,925	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	124,314	402	0	402	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	668,742	4,832	0	4,832	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	753,951	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	89,107	2,228	0	2,228	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	48,000	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	309,590	0	0	0	0	194.04
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)	4,698,942	3,366,106	330,349	1,150,365	814,665	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.063905	15.109688	0.655620	5.264660	102.409177	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	233,245	255,002	33,948	30,868	93,423	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 1/16/2018 3:01 pm

	Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (TOTAL FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TOTAL FEET)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.003172	1.144646	0.067374	0.141268	11.743935	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 1/16/2018 3:01 pm

		Cost Center Description	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	816,756					11.00
13.00	01300	NURSING ADMINISTRATION	25,290	281,892				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,204	4,204	100			14.00
15.00	01500	PHARMACY	15,383	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	33,343	0	0	0	200,227,357	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	104,902	104,902	0	0	11,100,282	30.00
31.00	03100	INTENSIVE CARE UNIT	35,465	35,465	0	0	1,995,911	31.00
41.00	04100	SUBPROVIDER - IRF	20,210	20,210	0	0	1,856,636	41.00
43.00	04300	NURSERY	6,313	6,313	0	0	675,431	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	56,676	56,676	0	0	31,001,255	50.00
53.00	05300	ANESTHESIOLOGY	243	0	0	0	3,489,516	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	63,450	0	0	0	38,020,982	54.00
60.00	06000	LABORATORY	64,190	0	0	0	28,041,519	60.00
65.00	06500	RESPIRATORY THERAPY	27,460	0	0	0	5,808,115	65.00
66.00	06600	PHYSICAL THERAPY	23,440	0	0	0	3,355,255	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,240	0	0	0	2,065,797	67.00
68.00	06800	SPEECH PATHOLOGY	3,610	0	0	0	657,049	68.00
69.00	06900	ELECTROCARDIOLOGY	12,458	0	0	0	5,457,512	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,672	0	0	0	155,063	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	100	0	6,812,458	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	4,664,200	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	10,811,878	73.00
76.00	03020	ONCOLOGY	4,545	0	0	0	223,288	76.00
76.97	07697	CARDIAC REHABILITATION	3,605	0	0	0	542,217	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	28,065	0	0	0	11,201,072	90.00
91.00	09100	EMERGENCY	54,122	54,122	0	0	19,715,418	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	19,947	0	0	0	1,574,485	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	614,833	281,892	100	100	189,225,339	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,213	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	138,706	0	0	0	11,002,018	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	2,380	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	44,716	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	1,436	0	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	9,472	0	0	0	0	194.04
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)	730,003	2,781,926	349,272	3,869,169	1,354,311	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.893783	9.868765	3,492.720000	38,691.690000	0.006764	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 1/16/2018 3:01 pm

		Cost Center Description	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	38,010	167,777	47,111	47,250	102,960	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.046538	0.595182	471.110000	472.500000	0.000514	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,241,872		8,241,872	0	8,241,872	30.00
31.00	03100	INTENSIVE CARE UNIT	2,831,465		2,831,465	0	2,831,465	31.00
41.00	04100	SUBPROVIDER - IRF	1,765,249		1,765,249	0	1,765,249	41.00
43.00	04300	NURSERY	452,922		452,922	0	452,922	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,947,347		6,947,347	0	6,947,347	50.00
53.00	05300	ANESTHESIOLOGY	179,252		179,252	0	179,252	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,829,384		5,829,384	0	5,829,384	54.00
60.00	06000	LABORATORY	5,599,209		5,599,209	0	5,599,209	60.00
65.00	06500	RESPIRATORY THERAPY	1,869,253	0	1,869,253	0	1,869,253	65.00
66.00	06600	PHYSICAL THERAPY	1,533,730	0	1,533,730	0	1,533,730	66.00
67.00	06700	OCCUPATIONAL THERAPY	429,105	0	429,105	0	429,105	67.00
68.00	06800	SPEECH PATHOLOGY	220,056	0	220,056	0	220,056	68.00
69.00	06900	ELECTROCARDIOLOGY	1,193,462		1,193,462	0	1,193,462	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	91,588		91,588	0	91,588	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,759,005		2,759,005	0	2,759,005	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,767,172		1,767,172	0	1,767,172	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,131,304		4,131,304	0	4,131,304	73.00
76.00	03020	ONCOLOGY	446,761		446,761	0	446,761	76.00
76.97	07697	CARDIAC REHABILITATION	310,744		310,744	0	310,744	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,785,930		3,785,930	0	3,785,930	90.00
91.00	09100	EMERGENCY	4,542,523		4,542,523	0	4,542,523	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,537,638		1,537,638		1,537,638	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,273,645		1,273,645		1,273,645	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	57,738,616	0	57,738,616	0	57,738,616	200.00
201.00		Less Observation Beds	1,537,638		1,537,638		1,537,638	201.00
202.00		Total (see instructions)	56,200,978	0	56,200,978	0	56,200,978	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,100,282		11,100,282			30.00
31.00	03100	INTENSIVE CARE UNIT	1,995,911		1,995,911			31.00
41.00	04100	SUBPROVIDER - IRF	1,856,636		1,856,636			41.00
43.00	04300	NURSERY	675,431		675,431			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,261,382	24,739,873	31,001,255	0.224099	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	757,859	2,731,657	3,489,516	0.051369	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,093,142	33,927,840	38,020,982	0.153320	0.000000	54.00
60.00	06000	LABORATORY	5,963,738	22,077,781	28,041,519	0.199676	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,923,539	2,884,576	5,808,115	0.321835	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,233,140	2,122,115	3,355,255	0.457113	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,212,604	853,193	2,065,797	0.207719	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	352,352	304,697	657,049	0.334916	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	844,395	4,398,429	5,242,824	0.227637	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	47,783	107,280	155,063	0.590650	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,558,153	3,254,305	6,812,458	0.404994	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,664,200	4,664,200	0.378880	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,717,274	6,094,603	10,811,877	0.382108	0.000000	73.00
76.00	03020	ONCOLOGY	2,200	152,554	154,754	2.886911	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	542,217	542,217	0.573099	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	61,559	10,945,431	11,006,990	0.343957	0.000000	90.00
91.00	09100	EMERGENCY	2,886,868	16,828,550	19,715,418	0.230405	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	145,085	1,477,406	1,622,491	0.947702	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,574,485	1,574,485			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	50,689,333	139,681,192	190,370,525			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	50,689,333	139,681,192	190,370,525			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.224099	50.00
53.00	05300	ANESTHESIOLOGY	0.051369	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.153320	54.00
60.00	06000	LABORATORY	0.199676	60.00
65.00	06500	RESPIRATORY THERAPY	0.321835	65.00
66.00	06600	PHYSICAL THERAPY	0.457113	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.207719	67.00
68.00	06800	SPEECH PATHOLOGY	0.334916	68.00
69.00	06900	ELECTROCARDIOLOGY	0.227637	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.590650	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.404994	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.378880	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.382108	73.00
76.00	03020	ONCOLOGY	2.886911	76.00
76.97	07697	CARDIAC REHABILITATION	0.573099	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.343957	90.00
91.00	09100	EMERGENCY	0.230405	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.947702	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
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: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 1/16/2018 3:01 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	8,241,872		8,241,872	0	8,241,872	30.00
31.00	03100	INTENSIVE CARE UNIT	2,831,465		2,831,465	0	2,831,465	31.00
41.00	04100	SUBPROVIDER - IRF	1,765,249		1,765,249	0	1,765,249	41.00
43.00	04300	NURSERY	452,922		452,922	0	452,922	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,947,347		6,947,347	0	6,947,347	50.00
53.00	05300	ANESTHESIOLOGY	179,252		179,252	0	179,252	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,829,384		5,829,384	0	5,829,384	54.00
60.00	06000	LABORATORY	5,599,209		5,599,209	0	5,599,209	60.00
65.00	06500	RESPIRATORY THERAPY	1,869,253	0	1,869,253	0	1,869,253	65.00
66.00	06600	PHYSICAL THERAPY	1,533,730	0	1,533,730	0	1,533,730	66.00
67.00	06700	OCCUPATIONAL THERAPY	429,105	0	429,105	0	429,105	67.00
68.00	06800	SPEECH PATHOLOGY	220,056	0	220,056	0	220,056	68.00
69.00	06900	ELECTROCARDIOLOGY	1,193,462		1,193,462	0	1,193,462	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	91,588		91,588	0	91,588	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,759,005		2,759,005	0	2,759,005	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,767,172		1,767,172	0	1,767,172	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,131,304		4,131,304	0	4,131,304	73.00
76.00	03020	ONCOLOGY	446,761		446,761	0	446,761	76.00
76.97	07697	CARDIAC REHABILITATION	310,744		310,744	0	310,744	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,785,930		3,785,930	0	3,785,930	90.00
91.00	09100	EMERGENCY	4,542,523		4,542,523	0	4,542,523	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,537,638		1,537,638		1,537,638	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,273,645		1,273,645		1,273,645	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	57,738,616	0	57,738,616	0	57,738,616	200.00
201.00		Less Observation Beds	1,537,638		1,537,638		1,537,638	201.00
202.00		Total (see instructions)	56,200,978	0	56,200,978	0	56,200,978	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 1/16/2018 3:01 pm

Title XIX | 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	11,100,282		11,100,282			30.00
31.00	03100	INTENSIVE CARE UNIT	1,995,911		1,995,911			31.00
41.00	04100	SUBPROVIDER - IRF	1,856,636		1,856,636			41.00
43.00	04300	NURSERY	675,431		675,431			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,261,382	24,739,873	31,001,255	0.224099	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	757,859	2,731,657	3,489,516	0.051369	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,093,142	33,927,840	38,020,982	0.153320	0.000000	54.00
60.00	06000	LABORATORY	5,963,738	22,077,781	28,041,519	0.199676	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,923,539	2,884,576	5,808,115	0.321835	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,233,140	2,122,115	3,355,255	0.457113	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,212,604	853,193	2,065,797	0.207719	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	352,352	304,697	657,049	0.334916	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	844,395	4,398,429	5,242,824	0.227637	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	47,783	107,280	155,063	0.590650	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,558,153	3,254,305	6,812,458	0.404994	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,664,200	4,664,200	0.378880	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,717,274	6,094,603	10,811,877	0.382108	0.000000	73.00
76.00	03020	ONCOLOGY	2,200	152,554	154,754	2.886911	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	542,217	542,217	0.573099	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	61,559	10,945,431	11,006,990	0.343957	0.000000	90.00
91.00	09100	EMERGENCY	2,886,868	16,828,550	19,715,418	0.230405	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	145,085	1,477,406	1,622,491	0.947702	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,574,485	1,574,485			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	50,689,333	139,681,192	190,370,525			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	50,689,333	139,681,192	190,370,525			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 1/16/2018 3:01 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
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	ONCOLOGY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part I | Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	642,382	0	642,382	6,684	96.11	30.00
31.00	INTENSIVE CARE UNIT	187,555		187,555	1,057	177.44	31.00
41.00	SUBPROVIDER - IRF	145,773	0	145,773	1,461	99.78	41.00
43.00	NURSERY	11,869		11,869	744	15.95	43.00
200.00	Total (lines 30-199)	987,579		987,579	9,946		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,551	245,177	30.00
31.00	INTENSIVE CARE UNIT	393	69,734	31.00
41.00	SUBPROVIDER - IRF	649	64,757	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	3,593	379,668	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,005,853	31,001,255	0.032446	2,423,189	78,623	50.00
53.00	05300	ANESTHESIOLOGY	22,532	3,489,516	0.006457	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	622,338	38,020,982	0.016368	1,998,964	32,719	54.00
60.00	06000	LABORATORY	333,167	28,041,519	0.011881	3,029,297	35,991	60.00
65.00	06500	RESPIRATORY THERAPY	92,490	5,808,115	0.015924	1,276,599	20,329	65.00
66.00	06600	PHYSICAL THERAPY	82,968	3,355,255	0.024728	303,025	7,493	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,461	2,065,797	0.010389	270,406	2,809	67.00
68.00	06800	SPEECH PATHOLOGY	4,770	657,049	0.007260	77,919	566	68.00
69.00	06900	ELECTROCARDIOLOGY	103,438	5,242,824	0.019729	735,504	14,511	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,580	155,063	0.035985	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	99,830	6,812,458	0.014654	2,085,282	30,558	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	13,683	4,664,200	0.002934	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	67,535	10,811,877	0.006246	2,039,471	12,739	73.00
76.00	03020	ONCOLOGY	72,410	154,754	0.467904	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	32,531	542,217	0.059996	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	190,767	11,006,990	0.017331	49,271	854	90.00
91.00	09100	EMERGENCY	273,878	19,715,418	0.013892	1,322,801	18,376	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	119,845	1,622,491	0.073865	127,315	9,404	92.00
200.00		Total (lines 50-199)	3,165,076	173,167,780		15,739,043	264,972	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,684	0.00	2,551	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,057	0.00	393	0		31.00
41.00	04100	SUBPROVIDER - IRF	1,461	0.00	649	0		41.00
43.00	04300	NURSERY	744	0.00	0	0		43.00
200.00		Total (lines 30-199)	9,946		3,593	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	31,001,255	0.000000	0.000000	2,423,189	50.00
53.00	05300	ANESTHESIOLOGY	0	3,489,516	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	38,020,982	0.000000	0.000000	1,998,964	54.00
60.00	06000	LABORATORY	0	28,041,519	0.000000	0.000000	3,029,297	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,808,115	0.000000	0.000000	1,276,599	65.00
66.00	06600	PHYSICAL THERAPY	0	3,355,255	0.000000	0.000000	303,025	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,065,797	0.000000	0.000000	270,406	67.00
68.00	06800	SPEECH PATHOLOGY	0	657,049	0.000000	0.000000	77,919	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,242,824	0.000000	0.000000	735,504	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	155,063	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,812,458	0.000000	0.000000	2,085,282	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,664,200	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,811,877	0.000000	0.000000	2,039,471	73.00
76.00	03020	ONCOLOGY	0	154,754	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	542,217	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	11,006,990	0.000000	0.000000	49,271	90.00
91.00	09100	EMERGENCY	0	19,715,418	0.000000	0.000000	1,322,801	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,622,491	0.000000	0.000000	127,315	92.00
200.00		Total (lines 50-199)	0	173,167,780			15,739,043	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	4,901,718	0		50.00
53.00	05300	ANESTHESIOLOGY	0	742,604	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,575,209	0		54.00
60.00	06000	LABORATORY	0	1,547,811	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	212,649	0		65.00
66.00	06600	PHYSICAL THERAPY	0	309	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,927	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	664	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,261,013	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	918,145	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	762,038	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,280,006	0		73.00
76.00	03020	ONCOLOGY	0	23,596	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	145,559	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	2,640,870	0		90.00
91.00	09100	EMERGENCY	0	3,079,683	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	573,081	0		92.00
200.00		Total (lines 50-199)	0	28,666,882	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.224099	4,901,718	0	0	1,098,470	50.00
53.00	05300	ANESTHESIOLOGY	0.051369	742,604	0	0	38,147	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.153320	8,575,209	0	0	1,314,751	54.00
60.00	06000	LABORATORY	0.199676	1,547,811	0	0	309,061	60.00
65.00	06500	RESPIRATORY THERAPY	0.321835	212,649	0	0	68,438	65.00
66.00	06600	PHYSICAL THERAPY	0.457113	309	0	0	141	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.207719	1,927	0	0	400	67.00
68.00	06800	SPEECH PATHOLOGY	0.334916	664	0	0	222	68.00
69.00	06900	ELECTROCARDIOLOGY	0.227637	2,261,013	0	0	514,690	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.590650	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.404994	918,145	0	0	371,843	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.378880	762,038	0	0	288,721	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.382108	2,280,006	219	4,145	871,209	73.00
76.00	03020	ONCOLOGY	2.886911	23,596	0	0	68,120	76.00
76.97	07697	CARDIAC REHABILITATION	0.573099	145,559	0	0	83,420	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.343957	2,640,870	432	0	908,346	90.00
91.00	09100	EMERGENCY	0.230405	3,079,683	0	0	709,574	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.947702	573,081	0	0	543,110	92.00
200.00		Subtotal (see instructions)		28,666,882	651	4,145	7,188,663	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		28,666,882	651	4,145	7,188,663	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	84	1,584		73.00
76.00	03020	ONCOLOGY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	149	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	233	1,584		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	233	1,584		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,005,853	31,001,255	0.032446	9,057	294	50.00
53.00	05300	ANESTHESIOLOGY	22,532	3,489,516	0.006457	2,020	13	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	622,338	38,020,982	0.016368	21,772	356	54.00
60.00	06000	LABORATORY	333,167	28,041,519	0.011881	165,413	1,965	60.00
65.00	06500	RESPIRATORY THERAPY	92,490	5,808,115	0.015924	102,880	1,638	65.00
66.00	06600	PHYSICAL THERAPY	82,968	3,355,255	0.024728	313,221	7,745	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,461	2,065,797	0.010389	328,712	3,415	67.00
68.00	06800	SPEECH PATHOLOGY	4,770	657,049	0.007260	120,725	876	68.00
69.00	06900	ELECTROCARDIOLOGY	103,438	5,242,824	0.019729	8,252	163	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,580	155,063	0.035985	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	99,830	6,812,458	0.014654	13,382	196	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	13,683	4,664,200	0.002934	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	67,535	10,811,877	0.006246	53,752	336	73.00
76.00	03020	ONCOLOGY	72,410	154,754	0.467904	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	32,531	542,217	0.059996	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	190,767	11,006,990	0.017331	0	0	90.00
91.00	09100	EMERGENCY	273,878	19,715,418	0.013892	2,148	30	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,622,491	0.000000	14,192	0	92.00
200.00		Total (lines 50-199)	3,045,231	173,167,780		1,155,526	17,027	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001
Component CCN: 15-T001

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

Worksheet D
Part IV
Date/Time Prepared:
1/16/2018 3:01 pm

Title XVIII

Subprovider - IRF

PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	31,001,255	0.000000	0.000000	9,057	50.00
53.00	05300	ANESTHESIOLOGY	0	3,489,516	0.000000	0.000000	2,020	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	38,020,982	0.000000	0.000000	21,772	54.00
60.00	06000	LABORATORY	0	28,041,519	0.000000	0.000000	165,413	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,808,115	0.000000	0.000000	102,880	65.00
66.00	06600	PHYSICAL THERAPY	0	3,355,255	0.000000	0.000000	313,221	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,065,797	0.000000	0.000000	328,712	67.00
68.00	06800	SPEECH PATHOLOGY	0	657,049	0.000000	0.000000	120,725	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,242,824	0.000000	0.000000	8,252	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	155,063	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,812,458	0.000000	0.000000	13,382	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,664,200	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,811,877	0.000000	0.000000	53,752	73.00
76.00	03020	ONCOLOGY	0	154,754	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	542,217	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	11,006,990	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	19,715,418	0.000000	0.000000	2,148	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,622,491	0.000000	0.000000	14,192	92.00
200.00		Total (lines 50-199)	0	173,167,780			1,155,526	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	636	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	544	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	60	0		73.00
76.00	03020	ONCOLOGY	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	1,240	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V | Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.224099	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.051369	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.153320	636	0	0	98	54.00
60.00	06000	LABORATORY	0.199676	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.321835	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.457113	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.207719	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.334916	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.227637	544	0	0	124	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.590650	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.404994	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.378880	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.382108	60	0	134	23	73.00
76.00	03020	ONCOLOGY	2.886911	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.573099	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.343957	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.230405	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.947702	0	0	0	0	92.00
200.00		Subtotal (see instructions)		1,240	0	134	245	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		1,240	0	134	245	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V | Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	51		73.00
76.00	03020	ONCOLOGY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	51		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	51		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,684	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,684	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)	5,437	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,551	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,241,872	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,241,872	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)	8,241,872	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)	1,233.07	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,145,562	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)	3,145,562	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,831,465	1,057	2,678.77	393	1,052,757	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)	4,319,665	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,517,984	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)	314,911	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	264,972	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	579,883	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,938,101	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,247	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,233.07	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,537,638	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	642,382	8,241,872	0.077941	1,537,638	119,845	90.00
91.00	Nursing School cost	0	8,241,872	0.000000	1,537,638	0	91.00
92.00	Allied health cost	0	8,241,872	0.000000	1,537,638	0	92.00
93.00	All other Medical Education	0	8,241,872	0.000000	1,537,638	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0001 Component CCN: 15-T001	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 1/16/2018 3:01 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,461	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,461	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)	1,461	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	649	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,765,249	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,765,249	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)	1,765,249	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)	1,208.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	784,154	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)	784,154	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	365,283	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,149,437	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)	64,757	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	17,027	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	81,784	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,067,653	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	145,773	1,765,249	0.082579	0	0	90.00
91.00	Nursing School cost	0	1,765,249	0.000000	0	0	91.00
92.00	Allied health cost	0	1,765,249	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,765,249	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 1/16/2018 3:01 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)	6,684	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,684	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)	5,437	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	69	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)	744	15.00
16.00	Nursery days (title V or XIX only)	58	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,241,872	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,241,872	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)	8,241,872	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)	1,233.07	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	85,082	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)	85,082	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 1/16/2018 3:01 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)	452,922	744	608.77	58	35,309	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,831,465	1,057	2,678.77	14	37,503	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)	76,271	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	234,165	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,247	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,233.07	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,537,638	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 1/16/2018 3:01 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	642,382	8,241,872	0.077941	1,537,638	119,845	90.00
91.00	Nursing School cost	0	8,241,872	0.000000	1,537,638	0	91.00
92.00	Allied health cost	0	8,241,872	0.000000	1,537,638	0	92.00
93.00	All other Medical Education	0	8,241,872	0.000000	1,537,638	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0001 Component CCN: 15-T001	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 1/16/2018 3:01 pm
	Title XIX	Subprovider - IRF	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)	1,461	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,461	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)	1,461	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	13	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)	744	15.00
16.00	Nursery days (title V or XIX only)	58	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,765,249	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,765,249	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)	1,765,249	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)	1,208.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	15,707	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)	15,707	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 1/16/2018 3:01 pm

Title XIX | Subprovider - IRF | 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	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,049	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	18,756	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 1/16/2018 3:01 pm

Title XIX | Subprovider - IRF | 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	145,773	1,765,249	0.082579	0	0	90.00
91.00	Nursing School cost	0	1,765,249	0.000000	0	0	91.00
92.00	Allied health cost	0	1,765,249	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,765,249	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,597,270		30.00
31.00	03100	INTENSIVE CARE UNIT		608,792		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.224099	2,423,189	543,034	50.00
53.00	05300	ANESTHESIOLOGY	0.051369	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.153320	1,998,964	306,481	54.00
60.00	06000	LABORATORY	0.199676	3,029,297	604,878	60.00
65.00	06500	RESPIRATORY THERAPY	0.321835	1,276,599	410,854	65.00
66.00	06600	PHYSICAL THERAPY	0.457113	303,025	138,517	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.207719	270,406	56,168	67.00
68.00	06800	SPEECH PATHOLOGY	0.334916	77,919	26,096	68.00
69.00	06900	ELECTROCARDIOLOGY	0.227637	735,504	167,428	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.590650	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.404994	2,085,282	844,527	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.378880	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.382108	2,039,471	779,298	73.00
76.00	03020	ONCOLOGY	2.886911	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.573099	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.343957	49,271	16,947	90.00
91.00	09100	EMERGENCY	0.230405	1,322,801	304,780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.947702	127,315	120,657	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		15,739,043	4,319,665	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)		15,739,043		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		799,824		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.224099	9,057	2,030	50.00
53.00	05300	ANESTHESIOLOGY	0.051369	2,020	104	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.153320	21,772	3,338	54.00
60.00	06000	LABORATORY	0.199676	165,413	33,029	60.00
65.00	06500	RESPIRATORY THERAPY	0.321835	102,880	33,110	65.00
66.00	06600	PHYSICAL THERAPY	0.457113	313,221	143,177	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.207719	328,712	68,280	67.00
68.00	06800	SPEECH PATHOLOGY	0.334916	120,725	40,433	68.00
69.00	06900	ELECTROCARDIOLOGY	0.227637	8,252	1,878	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.590650	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.404994	13,382	5,420	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.378880	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.382108	53,752	20,539	73.00
76.00	03020	ONCOLOGY	2.886911	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.573099	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.343957	0	0	90.00
91.00	09100	EMERGENCY	0.230405	2,148	495	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.947702	14,192	13,450	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,155,526	365,283	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,155,526		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 1/16/2018 3:01 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		187,329		30.00
31.00	03100	INTENSIVE CARE UNIT		10,864		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		53,378		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.224099	81,399	18,241	50.00
53.00	05300	ANESTHESIOLOGY	0.051369	12,628	649	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.153320	18,528	2,841	54.00
60.00	06000	LABORATORY	0.199676	51,491	10,282	60.00
65.00	06500	RESPIRATORY THERAPY	0.321835	22,792	7,335	65.00
66.00	06600	PHYSICAL THERAPY	0.457113	4,214	1,926	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.207719	4,138	860	67.00
68.00	06800	SPEECH PATHOLOGY	0.334916	1,068	358	68.00
69.00	06900	ELECTROCARDIOLOGY	0.227637	3,514	800	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.590650	338	200	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.404994	24,688	9,998	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.378880	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.382108	50,521	19,304	73.00
76.00	03020	ONCOLOGY	2.886911	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.573099	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.343957	0	0	90.00
91.00	09100	EMERGENCY	0.230405	15,089	3,477	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.947702	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		290,408	76,271	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)		290,408		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 1/16/2018 3:01 pm

Title XIX | Subprovider - IRF | 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
41.00	04100	SUBPROVIDER - IRF		9,277		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.224099	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.051369	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.153320	0	0	54.00
60.00	06000	LABORATORY	0.199676	282	56	60.00
65.00	06500	RESPIRATORY THERAPY	0.321835	604	194	65.00
66.00	06600	PHYSICAL THERAPY	0.457113	3,859	1,764	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.207719	3,819	793	67.00
68.00	06800	SPEECH PATHOLOGY	0.334916	709	237	68.00
69.00	06900	ELECTROCARDIOLOGY	0.227637	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.590650	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.404994	12	5	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.378880	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.382108	0	0	73.00
76.00	03020	ONCOLOGY	2.886911	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.573099	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.343957	0	0	90.00
91.00	09100	EMERGENCY	0.230405	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.947702	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		9,285	3,049	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)		9,285		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 1/16/2018 3:01 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	4,372,932	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,305,742	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	45,325	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	1,276,352	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	82.59	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.56	30.00
31.00	Percentage of Medicaid patient days (see instructions)	22.18	31.00
32.00	Sum of lines 30 and 31	25.74	32.00
33.00	Allowable disproportionate share percentage (see instructions)	10.45	33.00
34.00	Disproportionate share adjustment (see instructions)	148,356	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000046850	0.000048129	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	300,126	287,693	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	224,685	72,514	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	297,199		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	6,169,554		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	6,169,554	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	460,715	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	6,630,269	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	6,630,269	61.00
62.00	Deductibles billed to program beneficiaries	717,164	62.00
63.00	Coinsurance billed to program beneficiaries	3,220	63.00
64.00	Allowable bad debts (see instructions)	64,480	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	41,912	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	15,473	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	5,951,797	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	RURAL DEMONSTRATION PROJECT	0	70.50
70.88	SCH or MDH volume decrease adjustment	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-8,128	70.93
70.94	HRR adjustment amount (see instructions)	-5,247	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 1/16/2018 3:01 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		5,938,422	71.00
71.01	Sequestration adjustment (see instructions)		118,768	71.01
72.00	Interim payments		5,880,069	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		-60,415	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,367,147	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,372,932	0	4,372,932		4,372,932	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,305,742	0		1,305,742	1,305,742	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	45,325	0	29,953	15,372	45,325	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,276,352	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1045	0.1045	0.1045	0.1045		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	148,356	0	114,243	34,113	148,356	11.00
11.01	Uncompensated care payments	36.00	297,199	0	297,199	0	297,199	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,169,554	0	4,814,327	1,355,227	6,169,554	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,169,554	0	4,814,327	1,355,227	6,169,554	15.00
16.00	Payment for inpatient program capital	50.00	460,715	0	353,466	107,249	460,715	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	5,167,793	1,462,476	6,630,269	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	456,408	0	350,662	105,746	456,408	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	4,307	0	2,804	1,503	4,307	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	460,715	0	353,466	107,249	460,715	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.087679	0.092143		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			453,107		453,107	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				134,757	134,757	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,372,932	4,372,932		4,372,932	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,305,742		1,305,742	1,305,742	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	45,325	29,953	15,372	45,325	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,276,352	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1045	0.1045	0.1045		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	148,356	114,243	34,113	148,356	11.00
11.01	Uncompensated care payments	36.00	297,199	224,685	72,514	297,199	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,169,554	4,741,813	1,427,741	6,169,554	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,169,554	4,741,813	1,427,741	6,169,554	15.00
16.00	Payment for inpatient program capital	50.00	460,715	353,466	107,249	460,715	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			5,095,279	1,534,990	6,630,269	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	456,408	350,662	105,746	456,408	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	4,307	2,804	1,503	4,307	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	460,715	353,466	107,249	460,715	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-8,128	-13,847	5,719	-8,128	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-5,247	-5,247	0	-5,247	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 1/16/2018 3:01 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,817	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	7,188,663	2.00
3.00	PPS payments	5,646,973	3.00
4.00	Outlier payment (see instructions)	29,242	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)	1,817	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	4,796	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)	4,796	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)	4,796	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	2,979	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)	1,817	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)	5,676,215	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,185,635	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)	4,492,397	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)	4,492,397	30.00
31.00	Primary payer payments	1,850	31.00
32.00	Subtotal (line 30 minus line 31)	4,490,547	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)	200,299	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	130,194	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	146,232	36.00
37.00	Subtotal (see instructions)	4,620,741	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-98	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)	4,620,839	40.00
40.01	Sequestration adjustment (see instructions)	92,417	40.01
41.00	Interim payments	4,449,056	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	79,366	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001 Component CCN: 15-T001	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 1/16/2018 3:01 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	51	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	245	2.00
3.00	PPS payments	122	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)	51	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	134	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)	134	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)	134	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	83	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)	51	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)	122	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	12	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)	161	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)	161	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	161	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	161	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)	161	40.00
40.01	Sequestration adjustment (see instructions)	3	40.01
41.00	Interim payments	163	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-5	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: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,702,745		4,400,706	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	07/22/2016	32,700		0	3.01
3.02		12/31/2016	24,559	12/31/2016	118,891	3.02
3.03		07/21/2017	120,065		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	07/21/2017	70,541	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)		177,324		48,350	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)		5,880,069		4,449,056	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		79,366	6.01
6.02	SETTLEMENT TO PROGRAM		60,415		0	6.02
7.00	Total Medicare program liability (see instructions)		5,819,654		4,528,422	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: 15-0001 | Component CCN: 15-T001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		997,334		163	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	07/21/2017	15,737		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)		-15,737		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)		981,597		163	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		5	6.02
7.00	Total Medicare program liability (see instructions)		981,597		158	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: 15-0001	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 1/16/2018 3:01 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	2,053	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2,944	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	679	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	6,494	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	190,370,525	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	3,806,152	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	Provider CCN: 15-0001 Component CCN: 15-T001	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part III Date/Time Prepared: 1/16/2018 3:01 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	940,486	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0132	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	34,704	3.00
4.00	Outlier Payments	40,580	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	3.991803	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	1,015,770	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	1,015,770	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	1,015,770	19.00
20.00	Deductibles	11,564	20.00
21.00	Subtotal (line 19 minus line 20)	1,004,206	21.00
22.00	Coinsurance	2,576	22.00
23.00	Subtotal (line 21 minus line 22)	1,001,630	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	1,001,630	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	1,001,630	32.00
32.01	Sequestration adjustment (see instructions)	20,033	32.01
33.00	Interim payments	981,597	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)	0	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	32,291	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	40,580	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-3 Part VII Date/Time Prepared: 1/16/2018 3:01 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	234,165		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	234,165	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	234,165	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	260,187		8.00
9.00	Ancillary service charges	290,408	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	550,595	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	550,595	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	316,430	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	234,165	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	234,165	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	234,165	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	234,165	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	234,165	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	234,165	0	40.00
41.00	Interim payments	284,981	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-50,816	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001 Component CCN: 15-T001	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 1/16/2018 3:01 pm
	Title XIX	Subprovider - IRF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	18,756		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	18,756	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	18,756	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	9,277		8.00
9.00	Ancillary service charges	9,285	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	18,562	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	18,562	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	194	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	18,562	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	18,562	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	194	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	18,562	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	18,562	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	18,562	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	18,562	0	40.00
41.00	Interim payments	8,994	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	9,568	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 1/16/2018 3:01 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	44,512,427	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	17,292,322	0	0	0	4.00
5.00	Other receivable	49,091	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,533,137	0	0	0	7.00
8.00	Prepaid expenses	1,210,440	0	0	0	8.00
9.00	Other current assets	32,814,313	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)	97,411,730	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	4,743,329	0	0	0	12.00
13.00	Land improvements	2,746,206	0	0	0	13.00
14.00	Accumulated depreciation	-1,021,645	0	0	0	14.00
15.00	Buildings	68,972,645	0	0	0	15.00
16.00	Accumulated depreciation	-32,261,668	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	12,930,439	0	0	0	19.00
20.00	Accumulated depreciation	-9,995,647	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	50,480,013	0	0	0	23.00
24.00	Accumulated depreciation	-31,656,264	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)	64,937,408	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,424,783	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,424,783	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	164,773,921	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,622,786	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,134,595	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	488	0	0	0	43.00
44.00	Other current liabilities	22,493	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,780,362	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,780,362	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	155,993,559				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)	155,993,559	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	164,773,921	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 1/16/2018 3:01 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		138,670,754		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,347,087				2.00
3.00	Total (sum of line 1 and line 2)		136,323,667		0		3.00
4.00	TRANSFER FROM OTHER FUNDS	19,669,892		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)		19,669,892		0		10.00
11.00	Subtotal (line 3 plus line 10)		155,993,559		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		155,993,559		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	TRANSFER FROM OTHER FUNDS		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 1/16/2018 3:01 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	11,775,713		11,775,713	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	1,856,636		1,856,636	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)	13,632,349		13,632,349	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,995,911		1,995,911	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)	1,995,911		1,995,911	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	15,628,260		15,628,260	17.00
18.00	Ancillary services	31,967,561	108,595,779	140,563,340	18.00
19.00	Outpatient services	3,093,512	29,445,469	32,538,981	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		1,574,485	1,574,485	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	0	11,002,018	11,002,018	27.00
27.01	DIETARY	0	632	632	27.01
27.02	PRO FEES	54,628	488,135	542,763	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	50,743,961	151,106,518	201,850,479	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		82,973,583		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)		82,973,583		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0001	Period: From 01/01/2016 To 12/31/2016	Worksheet G-3 Date/Time Prepared: 1/16/2018 3:01 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	201,850,479	1.00
2.00	Less contractual allowances and discounts on patients' accounts	125,142,578	2.00
3.00	Net patient revenues (line 1 minus line 2)	76,707,901	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	82,973,583	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-6,265,682	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	OTHER INCOME	2,682,999	24.00
24.01	NON OP	1,235,658	24.01
24.02	MISC	-51	24.02
24.03		0	24.03
25.00	Total other income (sum of lines 6-24)	3,918,606	25.00
26.00	Total (line 5 plus line 25)	-2,347,076	26.00
27.00	ROUNDING	11	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	11	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,347,087	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H | Date/Time Prepared: 1/16/2018 3:01 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	193,059	0	47,569	0	103,379	344,007	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	252,558	0	0	0	0	252,558	6.00
7.00	Physical Therapy	166,272	0	0	0	0	166,272	7.00
8.00	Occupational Therapy	65,248	0	0	0	0	65,248	8.00
9.00	Speech Pathology	2,488	0	0	0	0	2,488	9.00
10.00	Medical Social Services	498	0	0	0	0	498	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	7,974	7,974	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	680,123	0	47,569	0	111,353	839,045	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	38,244	382,251	0	382,251			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	252,558	0	252,558			6.00
7.00	Physical Therapy	0	166,272	0	166,272			7.00
8.00	Occupational Therapy	0	65,248	0	65,248			8.00
9.00	Speech Pathology	0	2,488	0	2,488			9.00
10.00	Medical Social Services	0	498	0	498			10.00
11.00	Home Health Aide	0	0	0	0			11.00
12.00	Supplies (see instructions)	0	7,974	0	7,974			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	38,244	877,289	0	877,289			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 15-0001 HHA CCN: 15-7510 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H-1 Part I Date/Time Prepared: 1/16/2018 3:01 pm

Home Health Agency I | PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	382,251	0	0	0	0	382,251	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	252,558	0	0	0	0	252,558	6.00
7.00	Physical Therapy	166,272	0	0	0	0	166,272	7.00
8.00	Occupational Therapy	65,248	0	0	0	0	65,248	8.00
9.00	Speech Pathology	2,488	0	0	0	0	2,488	9.00
10.00	Medical Social Services	498	0	0	0	0	498	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	7,974	0	0	0	0	7,974	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	877,289	0	0	0	0	877,289	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	382,251		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	195,017	447,575	6.00
7.00	Physical Therapy	128,389	294,661	7.00
8.00	Occupational Therapy	50,382	115,630	8.00
9.00	Speech Pathology	1,921	4,409	9.00
10.00	Medical Social Services	385	883	10.00
11.00	Home Health Aide	0	0	11.00
12.00	Supplies (see instructions)	6,157	14,131	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		877,289	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H-1 Part II Date/Time Prepared: 1/16/2018 3:01 pm

Home Health Agency I | PPS

		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-382,251	495,038	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	252,558	6.00
7.00	Physical Therapy	0	0	0	0	0	166,272	7.00
8.00	Occupational Therapy	0	0	0	0	0	65,248	8.00
9.00	Speech Pathology	0	0	0	0	0	2,488	9.00
10.00	Medical Social Services	0	0	0	0	0	498	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	7,974	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-382,251	495,038	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		382,251	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.772165	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0001 HHA CCN: 15-7510

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

Worksheet H-2 Part I Date/Time Prepared: 1/16/2018 3:01 pm

Home Health Agency I

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	BLDG & FIXT - TOWER	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		0	1.00	1.01	2.00	4.00	4.01	
1.00	Administrative and General	0	9,519	0	56	164,801	9,570	1.00
2.00	Skilled Nursing Care	447,575	0	0	0	0	0	2.00
3.00	Physical Therapy	294,661	0	0	0	0	0	3.00
4.00	Occupational Therapy	115,630	0	0	0	0	0	4.00
5.00	Speech Pathology	4,409	0	0	0	0	0	5.00
6.00	Medical Social Services	883	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	14,131	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	877,289	9,519	0	56	164,801	9,570	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	DATA PROCESSING	MATERIALS MANAGEMENT	ADMITTING	PATIENT ACCOUNTING	Subtotal	ADMINISTRATIVE & GENERAL	
		4.02	4.03	4.04	4.05	4A.05	5.00	
1.00	Administrative and General	57,590	688	7,460	18,410	268,094	17,133	1.00
2.00	Skilled Nursing Care	0	0	0	0	447,575	28,603	2.00
3.00	Physical Therapy	0	0	0	0	294,661	18,830	3.00
4.00	Occupational Therapy	0	0	0	0	115,630	7,389	4.00
5.00	Speech Pathology	0	0	0	0	4,409	282	5.00
6.00	Medical Social Services	0	0	0	0	883	56	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	14,131	903	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	57,590	688	7,460	18,410	1,145,383	73,196	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0001 HHA CCN: 15-7510 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H-2 Part I Date/Time Prepared: 1/16/2018 3:01 pm

Home Health Agency I | PPS

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	19,718	0	6,870	0	17,828	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	19,718	0	6,870	0	17,828	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	10,650	340,293	0	340,293	1.00
2.00	Skilled Nursing Care	0	0	0	476,178	0	476,178	2.00
3.00	Physical Therapy	0	0	0	313,491	0	313,491	3.00
4.00	Occupational Therapy	0	0	0	123,019	0	123,019	4.00
5.00	Speech Pathology	0	0	0	4,691	0	4,691	5.00
6.00	Medical Social Services	0	0	0	939	0	939	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	15,034	0	15,034	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	10,650	1,273,645	0	1,273,645	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0001
HHA CCN: 15-7510

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

Worksheet H-2
Part I
Date/Time Prepared:
1/16/2018 3:01 pm

Home Health Agency I

PPS

	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs				
		27.00	28.00				
1.00	Administrative and General						1.00
2.00	Skilled Nursing Care	173,612	649,790				2.00
3.00	Physical Therapy	114,296	427,787				3.00
4.00	Occupational Therapy	44,852	167,871				4.00
5.00	Speech Pathology	1,710	6,401				5.00
6.00	Medical Social Services	342	1,281				6.00
7.00	Home Health Aide	0	0				7.00
8.00	Supplies (see instructions)	5,481	20,515				8.00
9.00	Drugs	0	0				9.00
10.00	DME	0	0				10.00
11.00	Home Dialysis Aide Services	0	0				11.00
12.00	Respiratory Therapy	0	0				12.00
13.00	Private Duty Nursing	0	0				13.00
14.00	Clinic	0	0				14.00
15.00	Health Promotion Activities	0	0				15.00
16.00	Day Care Program	0	0				16.00
17.00	Home Delivered Meals Program	0	0				17.00
18.00	Homemaker Service	0	0				18.00
19.00	All Others (specify)	0	0				19.00
19.50	Telemedicine	0	0				19.50
20.00	Total (sum of lines 1-19) (2)	340,293	1,273,645				20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.364592					21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0001 HHA CCN: 15-7510

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

Worksheet H-2 Part II Date/Time Prepared: 1/16/2018 3:01 pm

Home Health Agency I

PPS

	Cost Center Description	CAPITAL RELATED COSTS						
		NEW BLDG & FIXT (TOTAL FEET)	BLDG & FIXT - TOWER (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	DATA PROCESSING (WORK ORDERS)	
		1.00	1.01	2.00	4.00	4.01	4.02	
1.00	Administrative and General	1,305	0	56	718,367	23	45	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,305	0	56	718,367	23	45	20.00
21.00	Total cost to be allocated	9,519	0	56	164,801	9,570	57,590	21.00
22.00	Unit cost multiplier	7.294253	0.000000	1.000000	0.229411	416.086957	1,279.777778	22.00

	Cost Center Description	MATERIALS MANAGEMENT (SUPPLY USAGE)	ADMITTING (GROSS REVENUE)	PATIENT ACCOUNTING (GROSS REVENUE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (TOTAL FEET)	
		4.03	4.04	4.05	5A	5.00	7.00	
1.00	Administrative and General	11,913	1,574,485	1,574,485	0	268,094	1,305	1.00
2.00	Skilled Nursing Care	0	0	0	0	447,575	0	2.00
3.00	Physical Therapy	0	0	0	0	294,661	0	3.00
4.00	Occupational Therapy	0	0	0	0	115,630	0	4.00
5.00	Speech Pathology	0	0	0	0	4,409	0	5.00
6.00	Medical Social Services	0	0	0	0	883	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	14,131	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	11,913	1,574,485	1,574,485		1,145,383	1,305	20.00
21.00	Total cost to be allocated	688	7,460	18,410		73,196	19,718	21.00
22.00	Unit cost multiplier	0.057752	0.004738	0.011693		0.063905	15.109579	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0001 HHA CCN: 15-7510

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

Worksheet H-2 Part II Date/Time Prepared: 1/16/2018 3:01 pm

Home Health Agency I

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	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TOTAL FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	1,305	0	19,947	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	1,305	0	19,947	0	0	20.00
21.00	Total cost to be allocated	0	6,870	0	17,828	0	0	21.00
22.00	Unit cost multiplier	0.000000	5.264368	0.000000	0.893768	0.000000	0.000000	22.00

	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)					
		15.00	16.00					
1.00	Administrative and General	0	1,574,485					1.00
2.00	Skilled Nursing Care	0	0					2.00
3.00	Physical Therapy	0	0					3.00
4.00	Occupational Therapy	0	0					4.00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	0	0					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19)	0	1,574,485					20.00
21.00	Total cost to be allocated	0	10,650					21.00
22.00	Unit cost multiplier	0.000000	0.006764					22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H-3 Part I | Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	649,790		649,790	3,018	215.30	1.00
2.00	Physical Therapy	3.00	427,787	0	427,787	2,139	199.99	2.00
3.00	Occupational Therapy	4.00	167,871	0	167,871	1,252	134.08	3.00
4.00	Speech Pathology	5.00	6,401	0	6,401	32	200.03	4.00
5.00	Medical Social Services	6.00	1,281		1,281	2	640.50	5.00
6.00	Home Health Aide	7.00	0		0	0	0.00	6.00
7.00	Total (sum of lines 1-6)		1,253,130	0	1,253,130	6,443		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		18020	0	149			8.00
8.01	Skilled Nursing Care		26900	0	1,787			8.01
8.02	Skilled Nursing Care		50032	0	0			8.02
9.00	Physical Therapy		18020	0	123			9.00
9.01	Physical Therapy		26900	0	1,227			9.01
9.02	Physical Therapy		50032	0	0			9.02
10.00	Occupational Therapy		18020	0	79			10.00
10.01	Occupational Therapy		26900	0	769			10.01
10.02	Occupational Therapy		50032	0	0			10.02
11.00	Speech Pathology		18020	0	6			11.00
11.01	Speech Pathology		26900	0	11			11.01
11.02	Speech Pathology		50032	0	0			11.02
12.00	Medical Social Services		18020	0	0			12.00
12.01	Medical Social Services		26900	0	2			12.01
12.02	Medical Social Services		50032	0	0			12.02
13.00	Home Health Aide		18020	0	0			13.00
13.01	Home Health Aide		26900	0	0			13.01
13.02	Home Health Aide		50032	0	0			13.02
14.00	Total (sum of lines 8-13)			0	4,153			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	20,515	0	20,515	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,936		0	416,821		1.00
2.00	Physical Therapy	0	1,350		0	269,987		2.00
3.00	Occupational Therapy	0	848		0	113,700		3.00
4.00	Speech Pathology	0	17		0	3,401		4.00
5.00	Medical Social Services	0	2		0	1,281		5.00
6.00	Home Health Aide	0	0		0	0		6.00
7.00	Total (sum of lines 1-6)	0	4,153		0	805,190		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H-3 Part I | Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	416,821	1.00
2.00	Physical Therapy	269,987	2.00
3.00	Occupational Therapy	113,700	3.00
4.00	Speech Pathology	3,401	4.00
5.00	Medical Social Services	1,281	5.00
6.00	Home Health Aide	0	6.00
7.00	Total (sum of lines 1-6)	805,190	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
8.01	Skilled Nursing Care		8.01
8.02	Skilled Nursing Care		8.02
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
9.02	Physical Therapy		9.02
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
10.02	Occupational Therapy		10.02
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
11.02	Speech Pathology		11.02
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
12.02	Medical Social Services		12.02
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
13.02	Home Health Aide		13.02
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0001
HHA CCN: 15-7510

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

Worksheet H-3
Part II
Date/Time Prepared:
1/16/2018 3:01 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.457113	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.207719	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.334916	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.404994	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.382108	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H-4 Part I-II | Date/Time Prepared: 1/16/2018 3:01 pm

Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	5,467	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	-5,467	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	763,058	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	11,318	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	5,195	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	6,069	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	937	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	9	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	781,119	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	781,119	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	781,119	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	781,119	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	781,119	31.00
31.01	Sequestration adjustment (see instructions)	0	15,622	31.01
32.00	Interim payments (see instructions)	0	765,478	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	19	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-0001 | HHA CCN: 15-7510 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H-5 | Date/Time Prepared: 1/16/2018 3:01 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		765,478	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			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			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. H-4, Part II, column as appropriate, line 32)		0		765,478	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			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		19	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		765,497	7.00

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

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0001	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 1/16/2018 3:01 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	456,408	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	4,307	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	18.12	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	460,715	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00