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: 15-0006	Period: From 03/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/31/2017 9:24 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/31/2017 Time: 9:24 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LAPORTE HOSPITAL (15-0006) for the cost reporting period beginning 03/01/2016 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	131,239	86,603	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	131,239	86,603	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2017 9:23 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: STATE & MADISON STREETS	PO Box: 250			1.00
2.00	City: LAPORTE	State: IN	Zip Code: 46350-	County:	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	LAPORTE HOSPITAL	150006	43780	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	03/01/2016	12/31/2016	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	446	8	0	0	3,098	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2017 9:23 am

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

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

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

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		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)	N		0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2017 9:23 am

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	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.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	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.		Y	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	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)			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.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	24,548	97,296	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: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2017 9:23 am

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	449008	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: COMMUNITY HEALTH SYSTEMS	Contractor's Name: WPS	Contractor's Number: 10101	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	N	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: 15-0006	Period: From 03/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/31/2017 9:23 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2014	09/30/2014	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: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2017 9:23 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	Y	03/01/2016	1.00

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/28/2017	Y	04/28/2017	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 5/31/2017 9:23 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TYLER		LEACH		41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-3330		TYLER_LEACH@CHS.NET		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0006	Period: From 03/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/31/2017 9:23 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REVENUE MANAGER		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: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/31/2017 9:23 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	109	33,354	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)		109	33,354	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	20	6,120	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)		129	39,474	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		129				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: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2017 9:23 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,631	2,097	11,712			1.00
2.00	HMO and other (see instructions)	919	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	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)	6,631	2,097	11,712			7.00
8.00	INTENSIVE CARE UNIT	1,047	537	3,445			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		918	1,376			13.00
14.00	Total (see instructions)	7,678	3,552	16,533	0.00	855.32	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	855.32	27.00
28.00	Observation Bed Days		0	2,240			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2017 9:23 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,759	689	3,866	1.00
2.00	HMO and other (see instructions)			185	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,759	689	3,866	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2017 9:23 am

		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	43,086,307	0	43,086,307	1,349,996.00	31.92	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		319,013	0	319,013	2,280.00	139.92	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		0	0	0	0.00	0.00	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)		102,650	166,912	269,562	7,872.00	34.24	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,065,353	0	1,065,353	16,306.00	65.34	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		43,844	0	43,844	1,596.00	27.47	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)		10,994,695	0	10,994,695			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		269,562	7,872	277,434			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		319,013	2,280	321,293			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		1,118,260	7,051	1,125,311			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	536,293	0	536,293	12,781.00	41.96	26.00
27.00	Administrative & General	5.00	8,659,089	-166,912	8,492,177	253,399.00	33.51	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2017 9:23 am

		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.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,316,548	0	1,316,548	46,536.00	28.29	30.00
31.00	Laundry & Linen Service	8.00	50,688	0	50,688	4,119.00	12.31	31.00
32.00	Housekeeping	9.00	727,547	0	727,547	49,727.00	14.63	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,227,909	-844,323	383,586	34,631.00	11.08	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	844,323	844,323	40,152.00	21.03	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,435,219	0	2,435,219	74,572.00	32.66	38.00
39.00	Central Services and Supply	14.00	498,432	0	498,432	25,492.00	19.55	39.00
40.00	Pharmacy	15.00	1,525,194	0	1,525,194	41,933.00	36.37	40.00
41.00	Medical Records & Medical Records Library	16.00	919,977	0	919,977	48,475.00	18.98	41.00
42.00	Social Service	17.00	2,290	0	2,290	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: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-3 Part III Date/Time Prepared: 5/31/2017 9:23 am

		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)		43,086,307	0	43,086,307	1,349,996.00	31.92	1.00
2.00	Excluded area salaries (see instructions)		102,650	166,912	269,562	7,872.00	34.24	2.00
3.00	Subtotal salaries (line 1 minus line 2)		42,983,657	-166,912	42,816,745	1,342,124.00	31.90	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,109,197	0	1,109,197	17,902.00	61.96	4.00
5.00	Subtotal wage-related costs (see inst.)		11,313,708	2,280	11,315,988	0.00	26.43	5.00
6.00	Total (sum of lines 3 thru 5)		55,406,562	-164,632	55,241,930	1,360,026.00	40.62	6.00
7.00	Total overhead cost (see instructions)		17,899,186	-166,912	17,732,274	631,817.00	28.07	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-3 Part IV Date/Time Prepared: 5/31/2017 9:23 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	670,005	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)	0	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)	5,447,254	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	196,981	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	32,391	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	1,257	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	152,203	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,052,034	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	2,522,994	17.00
18.00	Medicare Taxes - Employers Portion Only	590,055	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	354,183	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	11,019,357	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	83,313	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-3 Part V Date/Time Prepared: 5/31/2017 9:23 am

	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	1,065,353	11,019,357	1.00
2.00	Hospital	1,065,353	11,019,357	2.00
3.00	Subprovider - IPF	0	0	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	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-7 | Date/Time Prepared: 5/31/2017 9:23 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.			2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	0	0	0	17.00
18.00		RHC	0	0	0	18.00
19.00		RHB	0	0	0	19.00
20.00		RHA	0	0	0	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	0	0	0	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	0	0	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	0	0	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-7 | Date/Time Prepared: 5/31/2017 9:23 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	0			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 5/31/2017 9:23 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.238809	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	9,687,520	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	85,750,056	6.00
7.00	Medicaid cost (line 1 times line 6)	20,477,885	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)	10,790,365	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	10,790,365	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	1,599,158	310,558	1,909,716	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	381,893	74,164	456,057	21.00
22.00	Partial payment by patients approved for charity care	5,097	110	5,207	22.00
23.00	Cost of charity care (line 21 minus line 22)	376,796	74,054	450,850	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,067,322	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	93,533	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	3,973,789	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	948,977	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,399,827	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	12,190,192	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/31/2017 9:23 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,906,159	3,906,159	959,251	4,865,410	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,947,284	5,947,284	551,589	6,498,873	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	536,293	285,012	821,305	7,616,068	8,437,373	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,659,089	35,568,469	44,227,558	-10,308,212	33,919,346	5.00
7.00	00700	OPERATION OF PLANT	1,316,548	3,304,270	4,620,818	-121,757	4,499,061	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	50,688	330,332	381,020	0	381,020	8.00
9.00	00900	HOUSEKEEPING	727,547	386,406	1,113,953	0	1,113,953	9.00
10.00	01000	DIETARY	1,227,909	1,143,621	2,371,530	-870,308	1,501,222	10.00
11.00	01100	CAFETERIA	0	0	0	897,139	897,139	11.00
13.00	01300	NURSING ADMINISTRATION	2,435,219	663,497	3,098,716	0	3,098,716	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	498,432	7,142,631	7,641,063	-6,697,314	943,749	14.00
15.00	01500	PHARMACY	1,525,194	4,119,282	5,644,476	-3,899,039	1,745,437	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	919,977	-126,283	793,694	-2,388	791,306	16.00
17.00	01700	SOCIAL SERVICE	2,290	0	2,290	0	2,290	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,073,181	3,041,786	8,114,967	423,638	8,538,605	30.00
31.00	03100	INTENSIVE CARE UNIT	2,171,287	629,917	2,801,204	-7,683	2,793,521	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,680,575	2,525,702	5,206,277	1,477	5,207,754	50.00
51.00	05100	RECOVERY ROOM	384,972	36,748	421,720	0	421,720	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,570,454	246,900	1,817,354	-460,779	1,356,575	52.00
53.00	05300	ANESTHESIOLOGY	44,766	2,356,280	2,401,046	0	2,401,046	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,650,514	1,548,852	4,199,366	-82,099	4,117,267	54.00
54.02	05402	ULTRASOUND	330,265	50,871	381,136	0	381,136	54.02
56.00	05600	RADIOISOTOPE	184,698	273,158	457,856	0	457,856	56.00
57.00	05700	CT SCAN	378,434	331,264	709,698	0	709,698	57.00
58.00	05800	MRI	213,159	162,677	375,836	0	375,836	58.00
60.00	06000	LABORATORY	2,691,324	2,671,100	5,362,424	-369,474	4,992,950	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	656,566	89,646	746,212	-5,588	740,624	65.00
66.00	06600	PHYSICAL THERAPY	1,078,006	652,682	1,730,688	-185,452	1,545,236	66.00
67.00	06700	OCCUPATIONAL THERAPY	70,734	4,969	75,703	211,476	287,179	67.00
68.00	06800	SPEECH PATHOLOGY	781,987	157,205	939,192	-26,024	913,168	68.00
69.00	06900	ELECTROCARDIOLOGY	2,032,902	3,175,882	5,208,784	-217,410	4,991,374	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,271,713	2,271,713	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,289,344	4,289,344	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,328,576	4,328,576	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	195,660	24,261	219,921	0	219,921	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DENTAL CLINIC	0	0	0	0	0	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	90.02
90.03	09003	DIABETIC TRAINING	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	1,894,987	612,105	2,507,092	-33	2,507,059	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	-120	-120	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	42,983,657	81,262,685	124,246,342	-1,703,409	122,542,933	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19001	PHYSICIAN RECRUITMENT	0	0	0	0	0	190.03
190.04	19002	MARKETING / PUBLIC RELATIONS	0	0	0	0	0	190.04
190.05	19003	SPORTS MEDICINE	0	0	0	0	0	190.05
190.06	19004	FOUNDATION	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-532,386	-532,386	1,376,053	843,667	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FREESTANDING VNA & HOSPICE	0	0	0	0	0	193.01
193.02	19302	WELLNESS CENTER	0	0	0	0	0	193.02
193.03	19303	RENTAL PROPERTIES	0	0	0	0	0	193.03
193.04	19304	STARKE HOSPITAL	0	0	0	0	0	193.04
193.05	19306	RETAIL PHARMACY	0	0	0	0	0	193.05
193.06	19305	VACANT	0	0	0	0	0	193.06

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/31/2017 9:23 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
193.07	19307	CONTINUING CARE - MILLERS	0	0	0	0	0	193.07
194.00	07951	OTHER NONREIMBURSABLE-MARKETING	102,650	32,624	135,274	327,356	462,630	194.00
200.00		TOTAL (SUM OF LINES 118-199)	43,086,307	80,762,923	123,849,230	0	123,849,230	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/31/2017 9:23 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-673,125	4,192,285		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	6,498,873		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-163,272	8,274,101		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-7,978,906	25,940,440		5.00
7.00	00700	OPERATION OF PLANT	0	4,499,061		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	381,020		8.00
9.00	00900	HOUSEKEEPING	0	1,113,953		9.00
10.00	01000	DIETARY	0	1,501,222		10.00
11.00	01100	CAFETERIA	-845,630	51,509		11.00
13.00	01300	NURSING ADMINISTRATION	-49,721	3,048,995		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	943,749		14.00
15.00	01500	PHARMACY	0	1,745,437		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-33,316	757,990		16.00
17.00	01700	SOCIAL SERVICE	0	2,290		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-46,888	8,491,717		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,793,521		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-198,935	5,008,819		50.00
51.00	05100	RECOVERY ROOM	0	421,720		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,356,575		52.00
53.00	05300	ANESTHESIOLOGY	-48,887	2,352,159		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-246	4,117,021		54.00
54.02	05402	ULTRASOUND	0	381,136		54.02
56.00	05600	RADIOISOTOPE	0	457,856		56.00
57.00	05700	CT SCAN	0	709,698		57.00
58.00	05800	MRI	0	375,836		58.00
60.00	06000	LABORATORY	-980,366	4,012,584		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	740,624		65.00
66.00	06600	PHYSICAL THERAPY	0	1,545,236		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	287,179		67.00
68.00	06800	SPEECH PATHOLOGY	0	913,168		68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,991,374		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-48,275	2,223,438		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,289,344		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-167	4,328,409		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0		76.00
76.01	03610	SLEEP LAB	0	219,921		76.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	DENTAL CLINIC	0	0		90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0		90.02
90.03	09003	DIABETIC TRAINING	0	0		90.03
91.00	09100	EMERGENCY	-41,976	2,465,083		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	-120		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-11,109,710	111,433,223		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.03	19001	PHYSICIAN RECRUITMENT	0	0		190.03
190.04	19002	MARKETING / PUBLIC RELATIONS	0	0		190.04
190.05	19003	SPORTS MEDICINE	0	0		190.05
190.06	19004	FOUNDATION	0	0		190.06
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	843,667		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	FREESTANDING VNA & HOSPICE	0	0		193.01
193.02	19302	WELLNESS CENTER	0	0		193.02
193.03	19303	RENTAL PROPERTIES	0	0		193.03
193.04	19304	STARKE HOSPITAL	0	0		193.04
193.05	19306	RETAIL PHARMACY	0	0		193.05
193.06	19305	VACANT	0	0		193.06
193.07	19307	CONTINUING CARE - MILLERS	0	0		193.07
194.00	07951	OTHER NONREIMBURSABLE-MARKETING	0	462,630		194.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/31/2017 9:23 am

	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
200.00	TOTAL (SUM OF LINES 118-199)	-11,109,710	112,739,520		200.00

RECLASSIFICATIONS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/31/2017 9:23 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,616,068	1.00
2.00	DIETARY	10.00	0	239	2.00
	0		0	7,616,307	
	B - OXYGEN COSTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	38,892	1.00
	TOTALS		0	38,892	
	C - RENTAL AND LEASE EXPENSES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	670,119	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	519,359	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,376,053	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	TOTALS		0	2,565,531	
	D - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	289,132	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	32,230	2.00
	TOTALS		0	321,362	
	E - MARKETING DEPARTMENT				
1.00	OTHER NONREIMBURSABLE-MARKETING	194.00	166,912	160,444	1.00
	TOTALS		166,912	160,444	
	F - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,286,358	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,289,344	2.00
3.00	DIETARY	10.00	0	28,127	3.00
4.00	PHARMACY	15.00	0	50,875	4.00
5.00	OPERATING ROOM	50.00	0	47,755	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	240	6.00
7.00	LABORATORY	60.00	0	9,188	7.00
	TOTALS		0	6,711,887	
	G - COST OF DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,328,576	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	4,328,576	
	H - LABOR AND DELIVERY COSTS				
1.00	ADULTS & PEDIATRICS	30.00	397,849	62,443	1.00
	TOTALS		397,849	62,443	
	I - PT, OT, SP COSTS				
1.00	OCCUPATIONAL THERAPY	67.00	124,182	87,294	1.00
2.00	SPEECH PATHOLOGY	68.00	0	27,321	2.00
	TOTALS		124,182	114,615	
	J - DIETARY COSTS TO CAFETERIA				
1.00	CAFETERIA	11.00	844,323	52,816	1.00
	TOTALS		844,323	52,816	
500.00	Grand Total: Increases		1,533,266	21,972,873	500.00

RECLASSIFICATIONS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/31/2017 9:23 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,611,028	0		1.00
2.00	OPERATION OF PLANT	7.00	0	5,279	0		2.00
	0		0	7,616,307			
	B - OXYGEN COSTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	38,892	0		1.00
	TOTALS		0	38,892			
	C - RENTAL AND LEASE EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,048,466	10		1.00
2.00	OPERATION OF PLANT	7.00	0	116,478	10		2.00
3.00	DIETARY	10.00	0	1,535	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	72	0		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,388	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	36,654	0		6.00
7.00	INTENSIVE CARE UNIT	31.00	0	7,683	0		7.00
8.00	OPERATING ROOM	50.00	0	46,278	0		8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	0	487	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	82,339	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	5,588	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	217,410	0		12.00
13.00	EMERGENCY	91.00	0	33	0		13.00
14.00	AMBULANCE SERVICES	95.00	0	120	0		14.00
	TOTALS		0	2,565,531			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	321,362	13		1.00
2.00		0.00	0	0	13		2.00
	TOTALS		0	321,362			
	E - MARKETING DEPARTMENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	166,912	160,444	0		1.00
	TOTALS		166,912	160,444			
	F - MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	53,537	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	6,658,350	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
	TOTALS		0	6,711,887			
	G - COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	3,949,914	0		1.00
2.00	LABORATORY	60.00	0	378,662	0		2.00
	TOTALS		0	4,328,576			
	H - LABOR AND DELIVERY COSTS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	397,849	62,443	0		1.00
	TOTALS		397,849	62,443			
	I - PT, OT, SP COSTS						
1.00	PHYSICAL THERAPY	66.00	70,837	114,615	0		1.00
2.00	SPEECH PATHOLOGY	68.00	53,345	0	0		2.00
	TOTALS		124,182	114,615			
	J - DIETARY COSTS TO CAFETERIA						
1.00	DIETARY	10.00	844,323	52,816	0		1.00
	TOTALS		844,323	52,816			
500.00	Grand Total: Decreases		1,533,266	21,972,873			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 5/31/2017 9:23 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,538,278	0	0	0	328,308	1.00
2.00	Land Improvements	1,549,559	0	0	0	288,525	2.00
3.00	Buildings and Fixtures	37,947,534	4,574,229	0	4,574,229	5,429,997	3.00
4.00	Building Improvements	27,936,535	1,032,424	0	1,032,424	5,601,352	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	68,971,906	5,606,653	0	5,606,653	11,648,182	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	68,971,906	5,606,653	0	5,606,653	11,648,182	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,209,970	0	1.00
2.00	Land Improvements	1,261,034	0	2.00
3.00	Buildings and Fixtures	37,091,766	0	3.00
4.00	Building Improvements	23,367,607	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	62,930,377	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	62,930,377	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet A-7 Part II | Date/Time Prepared: 5/31/2017 9:23 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,906,159	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,947,284	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	9,853,443	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	3,906,159		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,947,284		2.00
3.00	Total (sum of lines 1-2)	0	9,853,443		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 5/31/2017 9:23 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	35,713,171	0	35,713,171	0.567503	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	27,217,205	0	27,217,205	0.432497	0	2.00
3.00	Total (sum of lines 1-2)	62,930,376	0	62,930,376	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	CAP REL COSTS-BLDG & FIXT	0	0	0	3,906,159	670,119	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	5,947,284	519,359	2.00
3.00	Total (sum of lines 1-2)	0	0	0	9,853,443	1,189,478	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	CAP REL COSTS-BLDG & FIXT	-673,125	0	289,132	0	4,192,285	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	32,230	0	6,498,873	2.00
3.00	Total (sum of lines 1-2)	-673,125	0	321,362	0	10,691,158	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/31/2017 9:23 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		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)	A	-97,846	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-63,479	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,986,520			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	-162,222			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-845,630	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-48,275	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-167	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-33,316	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	SILVER RECOVERY	B	-246	RADIOLOGY-DIAGNOSTIC	54.00	0	33.00
40.00			0		0.00	0	40.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/31/2017 9:23 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
41.00	RENTAL INCOME	B	-673,125	CAP REL COSTS-BLDG & FIXT	1.00	11	41.00
42.00	MISC / NON PATIENT INCOME	B	-106,126	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	MISC / NON PATIENT INCOME	B	-1,431,018	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	TRAINING REVENUE	B	-17,694	NURSING ADMINISTRATION	13.00	0	44.00
45.00			0		0.00	0	45.00
45.01			0		0.00	0	45.01
45.02	MARKETING EXPENSE	A	-20,366	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	PHYSICIAN RECRUITING	A	-57,172	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04	PHYSICIAN RECRUITING	A	-163,272	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.04
45.05	CHARITABLE CONTRIBUTIONS	A	-111,966	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.06	MEDICAL STAFF STIPEND	A	-31,250	ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.07	MINORITY INTEREST	A	-1,211,133	ADMINISTRATIVE & GENERAL	5.00	0	45.07
45.08	CRNA SALARY COSTS	A	-48,887	ANESTHESIOLOGY	53.00	0	45.08
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,109,710				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/31/2017 9:23 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE EXPENSE	24,548	186,770	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			24,548	186,770	5.00

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

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

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

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

6.00	B		0.00	CHS	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0006	Period: From 03/01/2016 To 12/31/2016	Worksheet A-8-1 Date/Time Prepared: 5/31/2017 9:23 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-162,222	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-162,222			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 5/31/2017 9:23 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	4,686,328	4,686,328	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	32,027	32,027	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	46,888	46,888	0	0	0	3.00
4.00	50.00	OPERATING ROOM	198,935	198,935	0	0	0	4.00
5.00	60.00	LABORATORY	980,366	980,366	0	0	0	5.00
6.00	91.00	EMERGENCY	41,976	41,976	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			5,986,520	5,986,520	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	4,686,328		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	32,027		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	46,888		3.00
4.00	50.00	OPERATING ROOM	0	0	0	198,935		4.00
5.00	60.00	LABORATORY	0	0	0	980,366		5.00
6.00	91.00	EMERGENCY	0	0	0	41,976		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	5,986,520		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/31/2017 9:23 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,192,285	4,192,285				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	6,498,873		6,498,873			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,274,101	25,615	39,708	8,339,424		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,940,440	319,791	495,740	1,664,395	28,420,366	5.00
7.00	00700	OPERATION OF PLANT	4,499,061	1,234,773	1,914,142	258,032	7,906,008	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	381,020	3,464	5,369	9,934	399,787	8.00
9.00	00900	HOUSEKEEPING	1,113,953	50,360	78,068	142,593	1,384,974	9.00
10.00	01000	DIETARY	1,501,222	50,394	78,121	114,856	1,744,593	10.00
11.00	01100	CAFETERIA	51,509	32,939	51,062	125,803	261,313	11.00
13.00	01300	NURSING ADMINISTRATION	3,048,995	17,154	26,592	477,281	3,570,022	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	943,749	21,898	33,946	97,688	1,097,281	14.00
15.00	01500	PHARMACY	1,745,437	22,226	34,455	298,924	2,101,042	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	757,990	23,417	36,301	180,307	998,015	16.00
17.00	01700	SOCIAL SERVICE	2,290	8,385	12,999	449	24,123	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,491,717	199,084	308,620	1,072,273	10,071,694	30.00
31.00	03100	INTENSIVE CARE UNIT	2,793,521	91,882	142,436	425,553	3,453,392	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	7,968	12,352	0	20,320	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,008,819	226,163	350,598	525,369	6,110,949	50.00
51.00	05100	RECOVERY ROOM	421,720	0	0	75,451	497,171	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,356,575	110,111	170,694	229,820	1,867,200	52.00
53.00	05300	ANESTHESIOLOGY	2,352,159	0	0	8,774	2,360,933	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,117,021	81,532	126,391	519,477	4,844,421	54.00
54.02	05402	ULTRASOUND	381,136	13,423	20,809	64,729	480,097	54.02
56.00	05600	RADIOISOTOPE	457,856	0	0	36,199	494,055	56.00
57.00	05700	CT SCAN	709,698	13,471	20,883	74,170	818,222	57.00
58.00	05800	MRI	375,836	58,321	90,408	41,777	566,342	58.00
60.00	06000	LABORATORY	4,012,584	47,909	74,269	527,475	4,662,237	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	9,782	15,164	0	24,946	62.00
65.00	06500	RESPIRATORY THERAPY	740,624	8,748	13,561	128,681	891,614	65.00
66.00	06600	PHYSICAL THERAPY	1,545,236	222,337	344,666	197,396	2,309,635	66.00
67.00	06700	OCCUPATIONAL THERAPY	287,179	2,355	3,650	38,202	331,386	67.00
68.00	06800	SPEECH PATHOLOGY	913,168	1,390	2,154	142,807	1,059,519	68.00
69.00	06900	ELECTROCARDIOLOGY	4,991,374	168,158	260,678	398,430	5,818,640	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,223,438	0	0	0	2,223,438	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,289,344	0	0	0	4,289,344	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,328,409	0	0	0	4,328,409	73.00
74.00	07400	RENAL DIALYSIS	0	19,591	30,370	0	49,961	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	219,921	0	0	38,348	258,269	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DENTAL CLINIC	0	0	0	0	0	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	90.02
90.03	09003	DIABETIC TRAINING	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	2,465,083	67,123	104,055	371,400	3,007,661	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	-120	0	0	0	-120	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	111,433,223	3,159,764	4,898,261	8,286,593	108,747,259	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	37,648	58,362	0	96,010	190.00
190.03	19001	PHYSICIAN RECRUITMENT	0	0	0	0	0	190.03
190.04	19002	MARKETING / PUBLIC RELATIONS	0	0	0	32,713	32,713	190.04
190.05	19003	SPORTS MEDICINE	0	0	0	0	0	190.05
190.06	19004	FOUNDATION	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	843,667	0	0	0	843,667	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FREESTANDING VNA & HOSPICE	0	0	0	0	0	193.01
193.02	19302	WELLNESS CENTER	0	0	0	0	0	193.02
193.03	19303	RENTAL PROPERTIES	0	0	0	0	0	193.03

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/31/2017 9:23 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
193.04	19304	STARKE HOSPITAL	0	0	0	0	0	193.04
193.05	19306	RETAIL PHARMACY	0	0	0	0	0	193.05
193.06	19305	VACANT	0	0	0	0	0	193.06
193.07	19307	CONTINUING CARE - MILLERS	0	0	0	0	0	193.07
194.00	07951	OTHER NONREIMBURSABLE-MARKETING	462,630	994,873	1,542,250	20,118	3,019,871	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	112,739,520	4,192,285	6,498,873	8,339,424	112,739,520	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/31/2017 9:23 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,420,366					5.00
7.00	00700	OPERATION OF PLANT	2,664,775	10,570,783				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	134,751	14,017	548,555			8.00
9.00	00900	HOUSEKEEPING	466,815	203,798	274,275	2,329,862		9.00
10.00	01000	DIETARY	588,027	203,936	0	45,894	2,582,450	10.00
11.00	01100	CAFETERIA	88,077	133,298	0	29,998	1,291,230	11.00
13.00	01300	NURSING ADMINISTRATION	1,203,301	69,419	0	15,622	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	369,846	88,616	5,961	19,942	0	14.00
15.00	01500	PHARMACY	708,171	89,946	0	20,242	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	336,388	94,766	0	21,326	0	16.00
17.00	01700	SOCIAL SERVICE	8,131	33,934	0	7,637	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,394,700	805,662	86,599	181,309	1,118,630	30.00
31.00	03100	INTENSIVE CARE UNIT	1,163,990	371,833	30,211	83,678	101,932	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	6,849	32,244	3,638	7,256	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,059,738	915,248	36,127	205,970	300	50.00
51.00	05100	RECOVERY ROOM	167,575	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	629,353	445,602	8,089	100,279	58,271	52.00
53.00	05300	ANESTHESIOLOGY	795,769	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,632,846	329,949	18,379	74,253	0	54.00
54.02	05402	ULTRASOUND	161,820	54,322	0	12,225	0	54.02
56.00	05600	RADIOISOTOPE	166,525	0	0	0	0	56.00
57.00	05700	CT SCAN	275,787	54,516	0	12,268	0	57.00
58.00	05800	MRI	190,890	236,014	0	53,113	0	58.00
60.00	06000	LABORATORY	1,571,440	193,881	0	43,631	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,408	39,585	0	8,908	0	62.00
65.00	06500	RESPIRATORY THERAPY	300,525	35,402	0	7,967	0	65.00
66.00	06600	PHYSICAL THERAPY	778,479	899,763	1,273	202,485	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	111,696	9,529	333	2,144	0	67.00
68.00	06800	SPEECH PATHOLOGY	357,118	5,623	275	1,265	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,961,213	680,508	4,825	153,143	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	749,425	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,445,753	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,458,921	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	16,840	79,281	0	17,842	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	87,051	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DENTAL CLINIC	0	0	0	0	0	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	90.02
90.03	09003	DIABETIC TRAINING	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	1,013,753	271,638	30,900	61,130	12,087	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,074,746	6,392,330	500,885	1,389,527	2,582,450	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	32,361	152,357	79	34,287	0	190.00
190.03	19001	PHYSICIAN RECRUITMENT	0	0	0	0	0	190.03
190.04	19002	MARKETING / PUBLIC RELATIONS	11,026	0	0	0	0	190.04
190.05	19003	SPORTS MEDICINE	0	0	0	0	0	190.05
190.06	19004	FOUNDATION	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	284,364	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FREESTANDING VNA & HOSPICE	0	0	0	0	0	193.01
193.02	19302	WELLNESS CENTER	0	0	0	0	0	193.02
193.03	19303	RENTAL PROPERTIES	0	0	0	0	0	193.03
193.04	19304	STARKE HOSPITAL	0	0	0	0	0	193.04
193.05	19306	RETAIL PHARMACY	0	0	0	0	0	193.05
193.06	19305	VACANT	0	0	0	0	0	193.06
193.07	19307	CONTINUING CARE - MILLERS	0	0	0	0	0	193.07
194.00	07951	OTHER NONREIMBURSABLE-MARKETING	1,017,869	4,026,096	47,591	906,048	0	194.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/31/2017 9:23 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	28,420,366	10,570,783	548,555	2,329,862	2,582,450	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/31/2017 9:23 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,803,916					11.00
13.00	01300	NURSING ADMINISTRATION	140,254	4,998,618				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	51,427	0	1,633,073			14.00
15.00	01500	PHARMACY	79,248	406,884	1,566	3,407,099		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	90,131	0	995	0	1,541,621	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	379,912	1,459,526	55,956	0	74,801	30.00
31.00	03100	INTENSIVE CARE UNIT	138,798	579,245	37,807	0	27,280	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	154,931	696,240	118,773	0	306,479	50.00
51.00	05100	RECOVERY ROOM	0	0	486	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	58,056	312,822	14,087	0	44,320	52.00
53.00	05300	ANESTHESIOLOGY	0	0	7,270	0	55,864	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	161,599	0	44,464	255,443	37,840	54.00
54.02	05402	ULTRASOUND	0	0	2,154	0	1,445	54.02
56.00	05600	RADIOISOTOPE	0	0	408	116,981	24,833	56.00
57.00	05700	CT SCAN	21,920	0	4,902	0	96,497	57.00
58.00	05800	MRI	10,423	0	4,312	0	34,133	58.00
60.00	06000	LABORATORY	152,517	0	200,407	0	194,333	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	42,230	175,155	3,436	0	21,644	65.00
66.00	06600	PHYSICAL THERAPY	70,434	268,687	2,956	0	35,471	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,144	0	104	0	11,486	67.00
68.00	06800	SPEECH PATHOLOGY	34,527	0	1,027	0	4,745	68.00
69.00	06900	ELECTROCARDIOLOGY	99,979	542,327	270,979	0	132,472	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	289,283	1,471	59,426	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	536,436	0	63,129	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,033,204	208,750	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	5,071	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	52,197	523	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DENTAL CLINIC	0	0	0	0	0	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	90.02
90.03	09003	DIABETIC TRAINING	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	104,386	505,535	34,537	0	101,602	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,803,916	4,998,618	1,632,868	3,407,099	1,541,621	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19001	PHYSICIAN RECRUITMENT	0	0	0	0	0	190.03
190.04	19002	MARKETING / PUBLIC RELATIONS	0	0	0	0	0	190.04
190.05	19003	SPORTS MEDICINE	0	0	0	0	0	190.05
190.06	19004	FOUNDATION	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	205	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FREESTANDING VNA & HOSPICE	0	0	0	0	0	193.01
193.02	19302	WELLNESS CENTER	0	0	0	0	0	193.02
193.03	19303	RENTAL PROPERTIES	0	0	0	0	0	193.03
193.04	19304	STARKE HOSPITAL	0	0	0	0	0	193.04
193.05	19306	RETAIL PHARMACY	0	0	0	0	0	193.05
193.06	19305	VACANT	0	0	0	0	0	193.06
193.07	19307	CONTINUING CARE - MILLERS	0	0	0	0	0	193.07

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/31/2017 9:23 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
194.00	07951	OTHER NONREIMBURSABLE-MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,803,916	4,998,618	1,633,073	3,407,099	1,541,621	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/31/2017 9:23 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	73,825					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	52,298	17,681,087	0	17,681,087		30.00
31.00	03100	INTENSIVE CARE UNIT	15,383	6,003,549	0	6,003,549		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
43.00	04300	NURSERY	6,144	76,451	0	76,451		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	10,604,755	0	10,604,755		50.00
51.00	05100	RECOVERY ROOM	0	665,232	0	665,232		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,538,079	0	3,538,079		52.00
53.00	05300	ANESTHESIOLOGY	0	3,219,836	0	3,219,836		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,399,194	0	7,399,194		54.00
54.02	05402	ULTRASOUND	0	712,063	0	712,063		54.02
56.00	05600	RADIOISOTOPE	0	802,802	0	802,802		56.00
57.00	05700	CT SCAN	0	1,284,112	0	1,284,112		57.00
58.00	05800	MRI	0	1,095,227	0	1,095,227		58.00
60.00	06000	LABORATORY	0	7,018,446	0	7,018,446		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	81,847	0	81,847		62.00
65.00	06500	RESPIRATORY THERAPY	0	1,477,973	0	1,477,973		65.00
66.00	06600	PHYSICAL THERAPY	0	4,569,183	0	4,569,183		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	479,822	0	479,822		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,464,099	0	1,464,099		68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,664,086	0	9,664,086		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,323,043	0	3,323,043		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,334,662	0	6,334,662		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,029,284	0	9,029,284		73.00
74.00	07400	RENAL DIALYSIS	0	168,995	0	168,995		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	398,040	0	398,040		76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	DENTAL CLINIC	0	0	0	0		90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0		90.02
90.03	09003	DIABETIC TRAINING	0	0	0	0		90.03
91.00	09100	EMERGENCY	0	5,143,229	0	5,143,229		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	-120	0	-120		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	73,825	102,234,976	0	102,234,976		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	315,094	0	315,094		190.00
190.03	19001	PHYSICIAN RECRUITMENT	0	0	0	0		190.03
190.04	19002	MARKETING / PUBLIC RELATIONS	0	43,739	0	43,739		190.04
190.05	19003	SPORTS MEDICINE	0	0	0	0		190.05
190.06	19004	FOUNDATION	0	0	0	0		190.06
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,128,236	0	1,128,236		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	FREESTANDING VNA & HOSPICE	0	0	0	0		193.01
193.02	19302	WELLNESS CENTER	0	0	0	0		193.02
193.03	19303	RENTAL PROPERTIES	0	0	0	0		193.03
193.04	19304	STARKE HOSPITAL	0	0	0	0		193.04
193.05	19306	RETAIL PHARMACY	0	0	0	0		193.05

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/31/2017 9:23 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
193.06	19305	VACANT	0	0	0	0		193.06
193.07	19307	CONTINUING CARE - MILLERS	0	0	0	0		193.07
194.00	07951	OTHER NONREIMBURSABLE-MARKETING	0	9,017,475	0	9,017,475		194.00
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)	73,825	112,739,520	0	112,739,520		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/31/2017 9:23 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	25,615	39,708	65,323	65,323	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	319,791	495,740	815,531	13,042	5.00
7.00	00700	OPERATION OF PLANT	0	1,234,773	1,914,142	3,148,915	2,021	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,464	5,369	8,833	78	8.00
9.00	00900	HOUSEKEEPING	0	50,360	78,068	128,428	1,117	9.00
10.00	01000	DIETARY	0	50,394	78,121	128,515	900	10.00
11.00	01100	CAFETERIA	0	32,939	51,062	84,001	985	11.00
13.00	01300	NURSING ADMINISTRATION	0	17,154	26,592	43,746	3,738	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	21,898	33,946	55,844	765	14.00
15.00	01500	PHARMACY	0	22,226	34,455	56,681	2,341	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,417	36,301	59,718	1,412	16.00
17.00	01700	SOCIAL SERVICE	0	8,385	12,999	21,384	4	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	199,084	308,620	507,704	8,398	30.00
31.00	03100	INTENSIVE CARE UNIT	0	91,882	142,436	234,318	3,333	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	7,968	12,352	20,320	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	226,163	350,598	576,761	4,115	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	591	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	110,111	170,694	280,805	1,800	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	69	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	81,532	126,391	207,923	4,069	54.00
54.02	05402	ULTRASOUND	0	13,423	20,809	34,232	507	54.02
56.00	05600	RADIOISOTOPE	0	0	0	0	284	56.00
57.00	05700	CT SCAN	0	13,471	20,883	34,354	581	57.00
58.00	05800	MRI	0	58,321	90,408	148,729	327	58.00
60.00	06000	LABORATORY	0	47,909	74,269	122,178	4,131	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	9,782	15,164	24,946	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	8,748	13,561	22,309	1,008	65.00
66.00	06600	PHYSICAL THERAPY	0	222,337	344,666	567,003	1,546	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,355	3,650	6,005	299	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,390	2,154	3,544	1,118	68.00
69.00	06900	ELECTROCARDIOLOGY	0	168,158	260,678	428,836	3,121	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	19,591	30,370	49,961	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	300	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DENTAL CLINIC	0	0	0	0	0	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	90.02
90.03	09003	DIABETIC TRAINING	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	67,123	104,055	171,178	2,909	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,159,764	4,898,261	8,058,025	64,909	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	37,648	58,362	96,010	0	190.00
190.03	19001	PHYSICIAN RECRUITMENT	0	0	0	0	0	190.03
190.04	19002	MARKETING / PUBLIC RELATIONS	0	0	0	0	256	190.04
190.05	19003	SPORTS MEDICINE	0	0	0	0	0	190.05
190.06	19004	FOUNDATION	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FREESTANDING VNA & HOSPICE	0	0	0	0	0	193.01
193.02	19302	WELLNESS CENTER	0	0	0	0	0	193.02
193.03	19303	RENTAL PROPERTIES	0	0	0	0	0	193.03
193.04	19304	STARKE HOSPITAL	0	0	0	0	0	193.04

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/31/2017 9:23 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
193.05	19306	RETAIL PHARMACY	0	0	0	0	0	193.05
193.06	19305	VACANT	0	0	0	0	0	193.06
193.07	19307	CONTINUING CARE - MILLERS	0	0	0	0	0	193.07
194.00	07951	OTHER NONREIMBURSABLE-MARKETING	0	994,873	1,542,250	2,537,123	158	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	4,192,285	6,498,873	10,691,158	65,323	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/31/2017 9:23 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	828,573					5.00
7.00	00700	OPERATION OF PLANT	77,692	3,228,628				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,929	4,281	17,121			8.00
9.00	00900	HOUSEKEEPING	13,610	62,246	8,560	213,961		9.00
10.00	01000	DIETARY	17,144	62,288	0	4,215	213,062	10.00
11.00	01100	CAFETERIA	2,568	40,713	0	2,755	106,531	11.00
13.00	01300	NURSING ADMINISTRATION	35,083	21,203	0	1,435	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,783	27,066	186	1,831	0	14.00
15.00	01500	PHARMACY	20,647	27,472	0	1,859	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,807	28,944	0	1,958	0	16.00
17.00	01700	SOCIAL SERVICE	237	10,364	0	701	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	98,943	246,073	2,703	16,650	92,291	30.00
31.00	03100	INTENSIVE CARE UNIT	33,936	113,569	943	7,685	8,410	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	200	9,848	114	666	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	60,052	279,544	1,128	18,915	25	50.00
51.00	05100	RECOVERY ROOM	4,886	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,349	136,100	252	9,209	4,808	52.00
53.00	05300	ANESTHESIOLOGY	23,201	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,606	100,776	574	6,819	0	54.00
54.02	05402	ULTRASOUND	4,718	16,592	0	1,123	0	54.02
56.00	05600	RADIOISOTOPE	4,855	0	0	0	0	56.00
57.00	05700	CT SCAN	8,041	16,651	0	1,127	0	57.00
58.00	05800	MRI	5,565	72,086	0	4,878	0	58.00
60.00	06000	LABORATORY	45,816	59,217	0	4,007	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	245	12,090	0	818	0	62.00
65.00	06500	RESPIRATORY THERAPY	8,762	10,813	0	732	0	65.00
66.00	06600	PHYSICAL THERAPY	22,697	274,814	40	18,595	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,257	2,911	10	197	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,412	1,718	9	116	0	68.00
69.00	06900	ELECTROCARDIOLOGY	57,180	207,847	151	14,064	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,850	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,151	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,535	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	491	24,215	0	1,638	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,538	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DENTAL CLINIC	0	0	0	0	0	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	90.02
90.03	09003	DIABETIC TRAINING	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	29,556	82,966	964	5,614	997	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	789,342	1,952,407	15,634	127,607	213,062	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	943	46,534	2	3,149	0	190.00
190.03	19001	PHYSICIAN RECRUITMENT	0	0	0	0	0	190.03
190.04	19002	MARKETING / PUBLIC RELATIONS	321	0	0	0	0	190.04
190.05	19003	SPORTS MEDICINE	0	0	0	0	0	190.05
190.06	19004	FOUNDATION	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,291	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FREESTANDING VNA & HOSPICE	0	0	0	0	0	193.01
193.02	19302	WELLNESS CENTER	0	0	0	0	0	193.02
193.03	19303	RENTAL PROPERTIES	0	0	0	0	0	193.03
193.04	19304	STARKE HOSPITAL	0	0	0	0	0	193.04
193.05	19306	RETAIL PHARMACY	0	0	0	0	0	193.05
193.06	19305	VACANT	0	0	0	0	0	193.06
193.07	19307	CONTINUING CARE - MILLERS	0	0	0	0	0	193.07
194.00	07951	OTHER NONREIMBURSABLE-MARKETING	29,676	1,229,687	1,485	83,205	0	194.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/31/2017 9:23 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	828,573	3,228,628	17,121	213,961	213,062	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/31/2017 9:23 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	237,553					11.00
13.00	01300	NURSING ADMINISTRATION	18,470	123,675				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,772	0	103,247			14.00
15.00	01500	PHARMACY	10,436	10,066	99	129,601		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,869	0	63	0	113,771	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	50,029	36,120	3,538	0	5,520	30.00
31.00	03100	INTENSIVE CARE UNIT	18,278	14,330	2,390	0	2,013	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,402	17,225	7,509	0	22,628	50.00
51.00	05100	RECOVERY ROOM	0	0	31	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,645	7,739	891	0	3,271	52.00
53.00	05300	ANESTHESIOLOGY	0	0	460	0	4,122	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,281	0	2,811	9,717	2,792	54.00
54.02	05402	ULTRASOUND	0	0	136	0	107	54.02
56.00	05600	RADIOISOTOPE	0	0	26	4,450	1,832	56.00
57.00	05700	CT SCAN	2,887	0	310	0	7,121	57.00
58.00	05800	MRI	1,373	0	273	0	2,519	58.00
60.00	06000	LABORATORY	20,085	0	12,671	0	14,340	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	5,561	4,333	217	0	1,597	65.00
66.00	06600	PHYSICAL THERAPY	9,275	6,647	187	0	2,618	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,731	0	7	0	848	67.00
68.00	06800	SPEECH PATHOLOGY	4,547	0	65	0	350	68.00
69.00	06900	ELECTROCARDIOLOGY	13,166	13,417	17,133	0	9,775	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	18,290	56	4,385	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	33,910	0	4,658	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	115,378	15,404	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	374	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	1,291	33	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DENTAL CLINIC	0	0	0	0	0	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	90.02
90.03	09003	DIABETIC TRAINING	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	13,746	12,507	2,184	0	7,497	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	237,553	123,675	103,234	129,601	113,771	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19001	PHYSICIAN RECRUITMENT	0	0	0	0	0	190.03
190.04	19002	MARKETING / PUBLIC RELATIONS	0	0	0	0	0	190.04
190.05	19003	SPORTS MEDICINE	0	0	0	0	0	190.05
190.06	19004	FOUNDATION	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	13	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FREESTANDING VNA & HOSPICE	0	0	0	0	0	193.01
193.02	19302	WELLNESS CENTER	0	0	0	0	0	193.02
193.03	19303	RENTAL PROPERTIES	0	0	0	0	0	193.03
193.04	19304	STARKE HOSPITAL	0	0	0	0	0	193.04
193.05	19306	RETAIL PHARMACY	0	0	0	0	0	193.05
193.06	19305	VACANT	0	0	0	0	0	193.06
193.07	19307	CONTINUING CARE - MILLERS	0	0	0	0	0	193.07

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/31/2017 9:23 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
194.00	07951	OTHER NONREIMBURSABLE-MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	237,553	123,675	103,247	129,601	113,771	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/31/2017 9:23 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	32,690					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,157	1,091,126	0	1,091,126		30.00
31.00	03100	INTENSIVE CARE UNIT	6,812	446,017	0	446,017		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
43.00	04300	NURSERY	2,721	33,869	0	33,869		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,008,304	0	1,008,304		50.00
51.00	05100	RECOVERY ROOM	0	5,508	0	5,508		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	470,869	0	470,869		52.00
53.00	05300	ANESTHESIOLOGY	0	27,852	0	27,852		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	404,368	0	404,368		54.00
54.02	05402	ULTRASOUND	0	57,415	0	57,415		54.02
56.00	05600	RADIOISOTOPE	0	11,447	0	11,447		56.00
57.00	05700	CT SCAN	0	71,072	0	71,072		57.00
58.00	05800	MRI	0	235,750	0	235,750		58.00
60.00	06000	LABORATORY	0	282,445	0	282,445		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	38,099	0	38,099		62.00
65.00	06500	RESPIRATORY THERAPY	0	55,332	0	55,332		65.00
66.00	06600	PHYSICAL THERAPY	0	903,422	0	903,422		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	15,265	0	15,265		67.00
68.00	06800	SPEECH PATHOLOGY	0	21,879	0	21,879		68.00
69.00	06900	ELECTROCARDIOLOGY	0	764,690	0	764,690		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	44,581	0	44,581		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	80,719	0	80,719		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	173,317	0	173,317		73.00
74.00	07400	RENAL DIALYSIS	0	76,679	0	76,679		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	4,162	0	4,162		76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	DENTAL CLINIC	0	0	0	0		90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0		90.02
90.03	09003	DIABETIC TRAINING	0	0	0	0		90.03
91.00	09100	EMERGENCY	0	330,118	0	330,118		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	32,690	6,654,305	0	6,654,305		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	146,638	0	146,638		190.00
190.03	19001	PHYSICIAN RECRUITMENT	0	0	0	0		190.03
190.04	19002	MARKETING / PUBLIC RELATIONS	0	577	0	577		190.04
190.05	19003	SPORTS MEDICINE	0	0	0	0		190.05
190.06	19004	FOUNDATION	0	0	0	0		190.06
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8,304	0	8,304		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	FREESTANDING VNA & HOSPICE	0	0	0	0		193.01
193.02	19302	WELLNESS CENTER	0	0	0	0		193.02
193.03	19303	RENTAL PROPERTIES	0	0	0	0		193.03
193.04	19304	STARKE HOSPITAL	0	0	0	0		193.04
193.05	19306	RETAIL PHARMACY	0	0	0	0		193.05

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/31/2017 9:23 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
193.06	19305	VACANT	0	0	0	0		193.06
193.07	19307	CONTINUING CARE - MILLERS	0	0	0	0		193.07
194.00	07951	OTHER NONREIMBURSABLE-MARKETING	0	3,881,334	0	3,881,334		194.00
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)	32,690	10,691,158	0	10,691,158		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/31/2017 9:23 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	612,447					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		612,447				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,742	3,742	42,550,013			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	46,718	46,718	8,492,177	-28,420,366	84,319,274	5.00
7.00	00700	OPERATION OF PLANT	180,387	180,387	1,316,548	0	7,906,008	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	506	506	50,688	0	399,787	8.00
9.00	00900	HOUSEKEEPING	7,357	7,357	727,547	0	1,384,974	9.00
10.00	01000	DIETARY	7,362	7,362	586,029	0	1,744,593	10.00
11.00	01100	CAFETERIA	4,812	4,812	641,880	0	261,313	11.00
13.00	01300	NURSING ADMINISTRATION	2,506	2,506	2,435,219	0	3,570,022	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,199	3,199	498,432	0	1,097,281	14.00
15.00	01500	PHARMACY	3,247	3,247	1,525,194	0	2,101,042	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,421	3,421	919,977	0	998,015	16.00
17.00	01700	SOCIAL SERVICE	1,225	1,225	2,290	0	24,123	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,084	29,084	5,471,030	0	10,071,694	30.00
31.00	03100	INTENSIVE CARE UNIT	13,423	13,423	2,171,287	0	3,453,392	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	1,164	1,164	0	0	20,320	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,040	33,040	2,680,575	0	6,110,949	50.00
51.00	05100	RECOVERY ROOM	0	0	384,972	0	497,171	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,086	16,086	1,172,605	0	1,867,200	52.00
53.00	05300	ANESTHESIOLOGY	0	0	44,766	0	2,360,933	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,911	11,911	2,650,514	0	4,844,421	54.00
54.02	05402	ULTRASOUND	1,961	1,961	330,265	0	480,097	54.02
56.00	05600	RADIOISOTOPE	0	0	184,698	0	494,055	56.00
57.00	05700	CT SCAN	1,968	1,968	378,434	0	818,222	57.00
58.00	05800	MRI	8,520	8,520	213,159	0	566,342	58.00
60.00	06000	LABORATORY	6,999	6,999	2,691,324	0	4,662,237	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,429	1,429	0	0	24,946	62.00
65.00	06500	RESPIRATORY THERAPY	1,278	1,278	656,566	0	891,614	65.00
66.00	06600	PHYSICAL THERAPY	32,481	32,481	1,007,168	0	2,309,635	66.00
67.00	06700	OCCUPATIONAL THERAPY	344	344	194,915	0	331,386	67.00
68.00	06800	SPEECH PATHOLOGY	203	203	728,643	0	1,059,519	68.00
69.00	06900	ELECTROCARDIOLOGY	24,566	24,566	2,032,902	0	5,818,640	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,223,438	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,289,344	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,328,409	73.00
74.00	07400	RENAL DIALYSIS	2,862	2,862	0	0	49,961	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	195,660	0	258,269	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DENTAL CLINIC	0	0	0	0	0	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	90.02
90.03	09003	DIABETIC TRAINING	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	9,806	9,806	1,894,987	0	3,007,661	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	120	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	461,607	461,607	42,280,451	-28,420,246	80,327,013	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,500	5,500	0	0	96,010	190.00
190.03	19001	PHYSICIAN RECRUITMENT	0	0	0	0	0	190.03
190.04	19002	MARKETING / PUBLIC RELATIONS	0	0	166,912	0	32,713	190.04
190.05	19003	SPORTS MEDICINE	0	0	0	0	0	190.05
190.06	19004	FOUNDATION	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	843,667	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FREESTANDING VNA & HOSPICE	0	0	0	0	0	193.01
193.02	19302	WELLNESS CENTER	0	0	0	0	0	193.02
193.03	19303	RENTAL PROPERTIES	0	0	0	0	0	193.03

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/31/2017 9:23 am

		Cost Center Description	CAPITAL RELATED COSTS						
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)		
			1.00	2.00	4.00	5A	5.00		
193.04	19304	STARKE HOSPITAL	0	0	0	0	0	0	193.04
193.05	19306	RETAIL PHARMACY	0	0	0	0	0	0	193.05
193.06	19305	VACANT	0	0	0	0	0	0	193.06
193.07	19307	CONTINUING CARE - MILLERS	0	0	0	0	0	0	193.07
194.00	07951	OTHER NONREIMBURSABLE-MARKETING	145,340	145,340	102,650	0	3,019,871		194.00
200.00		Cross Foot Adjustments							200.00
201.00		Negative Cost Centers							201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,192,285	6,498,873	8,339,424		28,420,366		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.845139	10.611323	0.195991		0.337057		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			65,323		828,573		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001535		0.009827		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/31/2017 9:23 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	381,600					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	506	551,414				8.00
9.00	00900	HOUSEKEEPING	7,357	275,706	373,737			9.00
10.00	01000	DIETARY	7,362	0	7,362	214,943		10.00
11.00	01100	CAFETERIA	4,812	0	4,812	107,472	47,074	11.00
13.00	01300	NURSING ADMINISTRATION	2,506	0	2,506	0	3,660	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,199	5,992	3,199	0	1,342	14.00
15.00	01500	PHARMACY	3,247	0	3,247	0	2,068	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,421	0	3,421	0	2,352	16.00
17.00	01700	SOCIAL SERVICE	1,225	0	1,225	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,084	87,050	29,084	93,106	9,914	30.00
31.00	03100	INTENSIVE CARE UNIT	13,423	30,368	13,423	8,484	3,622	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	1,164	3,657	1,164	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,040	36,315	33,040	25	4,043	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,086	8,131	16,086	4,850	1,515	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,911	18,475	11,911	0	4,217	54.00
54.02	05402	ULTRASOUND	1,961	0	1,961	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	1,968	0	1,968	0	572	57.00
58.00	05800	MRI	8,520	0	8,520	0	272	58.00
60.00	06000	LABORATORY	6,999	0	6,999	0	3,980	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,429	0	1,429	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,278	0	1,278	0	1,102	65.00
66.00	06600	PHYSICAL THERAPY	32,481	1,280	32,481	0	1,838	66.00
67.00	06700	OCCUPATIONAL THERAPY	344	335	344	0	343	67.00
68.00	06800	SPEECH PATHOLOGY	203	276	203	0	901	68.00
69.00	06900	ELECTROCARDIOLOGY	24,566	4,850	24,566	0	2,609	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,862	0	2,862	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DENTAL CLINIC	0	0	0	0	0	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	90.02
90.03	09003	DIABETIC TRAINING	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	9,806	31,061	9,806	1,006	2,724	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	230,760	503,496	222,897	214,943	47,074	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,500	79	5,500	0	0	190.00
190.03	19001	PHYSICIAN RECRUITMENT	0	0	0	0	0	190.03
190.04	19002	MARKETING / PUBLIC RELATIONS	0	0	0	0	0	190.04
190.05	19003	SPORTS MEDICINE	0	0	0	0	0	190.05
190.06	19004	FOUNDATION	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FREESTANDING VNA & HOSPICE	0	0	0	0	0	193.01
193.02	19302	WELLNESS CENTER	0	0	0	0	0	193.02
193.03	19303	RENTAL PROPERTIES	0	0	0	0	0	193.03
193.04	19304	STARKE HOSPITAL	0	0	0	0	0	193.04
193.05	19306	RETAIL PHARMACY	0	0	0	0	0	193.05
193.06	19305	VACANT	0	0	0	0	0	193.06

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/31/2017 9:23 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
193.07	19307	CONTINUING CARE - MILLERS	0	0	0	0	0	193.07
194.00	07951	OTHER NONREIMBURSABLE-MARKETING	145,340	47,839	145,340	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	10,570,783	548,555	2,329,862	2,582,450	1,803,916	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.701213	0.994815	6.233961	12.014581	38.320857	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,228,628	17,121	213,961	213,062	237,553	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.460765	0.031049	0.572491	0.991249	5.046374	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/31/2017 9:23 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (BILLABLE SUPPLIE)	PHARMACY (100% ALLOCAT)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	18,737,238					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,895,171				14.00
15.00	01500	PHARMACY	1,525,194	12,368	4,862,148			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,855	0	418,230,187		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	16,533	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,471,030	441,842	0	20,293,379	11,712	30.00
31.00	03100	INTENSIVE CARE UNIT	2,171,287	298,535	0	7,400,916	3,445	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	1,376	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,609,839	937,866	0	83,139,909	0	50.00
51.00	05100	RECOVERY ROOM	0	3,839	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,172,605	111,233	0	12,023,900	0	52.00
53.00	05300	ANESTHESIOLOGY	0	57,407	0	15,155,677	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	351,102	364,534	10,265,889	0	54.00
54.02	05402	ULTRASOUND	0	17,007	0	391,937	0	54.02
56.00	05600	RADIOISOTOPE	0	3,221	166,939	6,737,061	0	56.00
57.00	05700	CT SCAN	0	38,706	0	26,179,296	0	57.00
58.00	05800	MRI	0	34,046	0	9,260,198	0	58.00
60.00	06000	LABORATORY	0	1,582,471	0	52,721,875	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	656,566	27,135	0	5,872,059	0	65.00
66.00	06600	PHYSICAL THERAPY	1,007,168	23,345	0	9,623,191	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	825	0	3,115,996	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,109	0	1,287,427	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,032,902	2,139,724	0	35,939,246	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,284,259	2,099	16,122,166	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,235,808	0	17,126,806	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,328,576	56,633,334	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,375,611	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	195,660	4,133	0	77	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DENTAL CLINIC	0	0	0	0	0	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	90.02
90.03	09003	DIABETIC TRAINING	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	1,894,987	272,716	0	27,564,237	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,737,238	12,893,552	4,862,148	418,230,187	16,533	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.03	19001	PHYSICIAN RECRUITMENT	0	0	0	0	0	190.03
190.04	19002	MARKETING / PUBLIC RELATIONS	0	0	0	0	0	190.04
190.05	19003	SPORTS MEDICINE	0	0	0	0	0	190.05
190.06	19004	FOUNDATION	0	0	0	0	0	190.06
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,619	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	FREESTANDING VNA & HOSPICE	0	0	0	0	0	193.01
193.02	19302	WELLNESS CENTER	0	0	0	0	0	193.02
193.03	19303	RENTAL PROPERTIES	0	0	0	0	0	193.03
193.04	19304	STARKE HOSPITAL	0	0	0	0	0	193.04
193.05	19306	RETAIL PHARMACY	0	0	0	0	0	193.05

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/31/2017 9:23 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (BILLABLE SUPPLIE)	PHARMACY (100% ALLOCAT)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
193.06	19305	VACANT	0	0	0	0	0	193.06
193.07	19307	CONTINUING CARE - MILLERS	0	0	0	0	0	193.07
194.00	07951	OTHER NONREIMBURSABLE-MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,998,618	1,633,073	3,407,099	1,541,621	73,825	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.266775	0.126642	0.700739	0.003686	4.465312	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	123,675	103,247	129,601	113,771	32,690	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006600	0.008007	0.026655	0.000272	1.977258	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/31/2017 9:23 am

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		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	17,681,087		17,681,087	0	17,681,087	30.00
31.00	03100	INTENSIVE CARE UNIT	6,003,549		6,003,549	0	6,003,549	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
43.00	04300	NURSERY	76,451		76,451	0	76,451	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,604,755		10,604,755	0	10,604,755	50.00
51.00	05100	RECOVERY ROOM	665,232		665,232	0	665,232	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,538,079		3,538,079	0	3,538,079	52.00
53.00	05300	ANESTHESIOLOGY	3,219,836		3,219,836	0	3,219,836	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,399,194		7,399,194	0	7,399,194	54.00
54.02	05402	ULTRASOUND	712,063		712,063	0	712,063	54.02
56.00	05600	RADIOISOTOPE	802,802		802,802	0	802,802	56.00
57.00	05700	CT SCAN	1,284,112		1,284,112	0	1,284,112	57.00
58.00	05800	MRI	1,095,227		1,095,227	0	1,095,227	58.00
60.00	06000	LABORATORY	7,018,446		7,018,446	0	7,018,446	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	81,847		81,847	0	81,847	62.00
65.00	06500	RESPIRATORY THERAPY	1,477,973	0	1,477,973	0	1,477,973	65.00
66.00	06600	PHYSICAL THERAPY	4,569,183	0	4,569,183	0	4,569,183	66.00
67.00	06700	OCCUPATIONAL THERAPY	479,822	0	479,822	0	479,822	67.00
68.00	06800	SPEECH PATHOLOGY	1,464,099	0	1,464,099	0	1,464,099	68.00
69.00	06900	ELECTROCARDIOLOGY	9,664,086		9,664,086	0	9,664,086	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,323,043		3,323,043	0	3,323,043	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,334,662		6,334,662	0	6,334,662	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,029,284		9,029,284	0	9,029,284	73.00
74.00	07400	RENAL DIALYSIS	168,995		168,995	0	168,995	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0		0	0	0	76.00
76.01	03610	SLEEP LAB	398,040		398,040	0	398,040	76.01
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	DENTAL CLINIC	0		0	0	0	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0		0	0	0	90.02
90.03	09003	DIABETIC TRAINING	0		0	0	0	90.03
91.00	09100	EMERGENCY	5,143,229		5,143,229	0	5,143,229	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,838,707		2,838,707		2,838,707	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	105,073,803	0	105,073,803	0	105,073,803	200.00
201.00		Less Observation Beds	2,838,707		2,838,707		2,838,707	201.00
202.00		Total (see instructions)	102,235,096	0	102,235,096	0	102,235,096	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/31/2017 9:23 am

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		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	17,159,625		17,159,625			30.00
31.00	03100	INTENSIVE CARE UNIT	7,300,166		7,300,166			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	1,686,314		1,686,314			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,257,216	49,565,164	78,822,380	0.134540	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,126,599	3,252,099	4,378,698	0.151925	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,310,546	713,354	12,023,900	0.294254	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,743,164	10,412,513	15,155,677	0.212451	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,955,337	8,310,552	10,265,889	0.720755	0.000000	54.00
54.02	05402	ULTRASOUND	762,365	4,555,742	5,318,107	0.133894	0.000000	54.02
56.00	05600	RADIOISOTOPE	995,044	5,742,017	6,737,061	0.119162	0.000000	56.00
57.00	05700	CT SCAN	5,459,068	15,402,121	20,861,189	0.061555	0.000000	57.00
58.00	05800	MRI	1,222,748	8,037,450	9,260,198	0.118273	0.000000	58.00
60.00	06000	LABORATORY	16,239,846	36,229,519	52,469,365	0.133763	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	16,102	236,407	252,509	0.324135	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	4,920,129	951,930	5,872,059	0.251696	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,174,491	6,736,873	7,911,364	0.577547	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,516,882	1,599,114	3,115,996	0.153987	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	438,204	2,561,051	2,999,255	0.488154	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	9,419,978	23,936,379	33,356,357	0.289722	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,550,266	8,571,900	16,122,166	0.206116	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,092,276	7,034,530	17,126,806	0.369868	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,862,513	28,770,821	56,633,334	0.159434	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,375,611	0	1,375,611	0.122851	0.000000	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	189,104	2,785,799	2,974,903	0.133799	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	DENTAL CLINIC	0	0	0	0.000000	0.000000	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0.000000	0.000000	90.02
90.03	09003	DIABETIC TRAINING	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	4,715,647	22,848,590	27,564,237	0.186591	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,625,519	9,735,699	11,361,218	0.249859	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	170,114,760	257,989,624	428,104,384			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	170,114,760	257,989,624	428,104,384			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/31/2017 9:23 am

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		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
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.134540		50.00
51.00	05100	RECOVERY ROOM	0.151925		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.294254		52.00
53.00	05300	ANESTHESIOLOGY	0.212451		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.720755		54.00
54.02	05402	ULTRASOUND	0.133894		54.02
56.00	05600	RADIOISOTOPE	0.119162		56.00
57.00	05700	CT SCAN	0.061555		57.00
58.00	05800	MRI	0.118273		58.00
60.00	06000	LABORATORY	0.133763		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.324135		62.00
65.00	06500	RESPIRATORY THERAPY	0.251696		65.00
66.00	06600	PHYSICAL THERAPY	0.577547		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.153987		67.00
68.00	06800	SPEECH PATHOLOGY	0.488154		68.00
69.00	06900	ELECTROCARDIOLOGY	0.289722		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.206116		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.369868		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.159434		73.00
74.00	07400	RENAL DIALYSIS	0.122851		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000		76.00
76.01	03610	SLEEP LAB	0.133799		76.01
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	DENTAL CLINIC	0.000000		90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0.000000		90.02
90.03	09003	DIABETIC TRAINING	0.000000		90.03
91.00	09100	EMERGENCY	0.186591		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.249859		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
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: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/31/2017 9:23 am

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		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	17,681,087		17,681,087	0	17,681,087	30.00
31.00	03100	INTENSIVE CARE UNIT	6,003,549		6,003,549	0	6,003,549	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
43.00	04300	NURSERY	76,451		76,451	0	76,451	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,604,755		10,604,755	0	10,604,755	50.00
51.00	05100	RECOVERY ROOM	665,232		665,232	0	665,232	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,538,079		3,538,079	0	3,538,079	52.00
53.00	05300	ANESTHESIOLOGY	3,219,836		3,219,836	0	3,219,836	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,399,194		7,399,194	0	7,399,194	54.00
54.02	05402	ULTRASOUND	712,063		712,063	0	712,063	54.02
56.00	05600	RADIOISOTOPE	802,802		802,802	0	802,802	56.00
57.00	05700	CT SCAN	1,284,112		1,284,112	0	1,284,112	57.00
58.00	05800	MRI	1,095,227		1,095,227	0	1,095,227	58.00
60.00	06000	LABORATORY	7,018,446		7,018,446	0	7,018,446	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	81,847		81,847	0	81,847	62.00
65.00	06500	RESPIRATORY THERAPY	1,477,973	0	1,477,973	0	1,477,973	65.00
66.00	06600	PHYSICAL THERAPY	4,569,183	0	4,569,183	0	4,569,183	66.00
67.00	06700	OCCUPATIONAL THERAPY	479,822	0	479,822	0	479,822	67.00
68.00	06800	SPEECH PATHOLOGY	1,464,099	0	1,464,099	0	1,464,099	68.00
69.00	06900	ELECTROCARDIOLOGY	9,664,086		9,664,086	0	9,664,086	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,323,043		3,323,043	0	3,323,043	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,334,662		6,334,662	0	6,334,662	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,029,284		9,029,284	0	9,029,284	73.00
74.00	07400	RENAL DIALYSIS	168,995		168,995	0	168,995	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0		0	0	0	76.00
76.01	03610	SLEEP LAB	398,040		398,040	0	398,040	76.01
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	DENTAL CLINIC	0		0	0	0	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0		0	0	0	90.02
90.03	09003	DIABETIC TRAINING	0		0	0	0	90.03
91.00	09100	EMERGENCY	5,143,229		5,143,229	0	5,143,229	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,838,707		2,838,707		2,838,707	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	105,073,803	0	105,073,803	0	105,073,803	200.00
201.00		Less Observation Beds	2,838,707		2,838,707		2,838,707	201.00
202.00		Total (see instructions)	102,235,096	0	102,235,096	0	102,235,096	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet C Part I | Date/Time Prepared: 5/31/2017 9:23 am

Title XIX | 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	17,159,625		17,159,625			30.00
31.00	03100	INTENSIVE CARE UNIT	7,300,166		7,300,166			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	1,686,314		1,686,314			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,257,216	49,565,164	78,822,380	0.134540	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,126,599	3,252,099	4,378,698	0.151925	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,310,546	713,354	12,023,900	0.294254	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,743,164	10,412,513	15,155,677	0.212451	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,955,337	8,310,552	10,265,889	0.720755	0.000000	54.00
54.02	05402	ULTRASOUND	762,365	4,555,742	5,318,107	0.133894	0.000000	54.02
56.00	05600	RADIOISOTOPE	995,044	5,742,017	6,737,061	0.119162	0.000000	56.00
57.00	05700	CT SCAN	5,459,068	15,402,121	20,861,189	0.061555	0.000000	57.00
58.00	05800	MRI	1,222,748	8,037,450	9,260,198	0.118273	0.000000	58.00
60.00	06000	LABORATORY	16,239,846	36,229,519	52,469,365	0.133763	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	16,102	236,407	252,509	0.324135	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	4,920,129	951,930	5,872,059	0.251696	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,174,491	6,736,873	7,911,364	0.577547	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,516,882	1,599,114	3,115,996	0.153987	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	438,204	2,561,051	2,999,255	0.488154	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	9,419,978	23,936,379	33,356,357	0.289722	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,550,266	8,571,900	16,122,166	0.206116	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,092,276	7,034,530	17,126,806	0.369868	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,862,513	28,770,821	56,633,334	0.159434	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,375,611	0	1,375,611	0.122851	0.000000	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	189,104	2,785,799	2,974,903	0.133799	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	DENTAL CLINIC	0	0	0	0.000000	0.000000	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0.000000	0.000000	90.02
90.03	09003	DIABETIC TRAINING	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	4,715,647	22,848,590	27,564,237	0.186591	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,625,519	9,735,699	11,361,218	0.249859	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	170,114,760	257,989,624	428,104,384			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	170,114,760	257,989,624	428,104,384			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/31/2017 9:23 am

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		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
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.134540		50.00
51.00	05100	RECOVERY ROOM	0.151925		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.294254		52.00
53.00	05300	ANESTHESIOLOGY	0.212451		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.720755		54.00
54.02	05402	ULTRASOUND	0.133894		54.02
56.00	05600	RADIOISOTOPE	0.119162		56.00
57.00	05700	CT SCAN	0.061555		57.00
58.00	05800	MRI	0.118273		58.00
60.00	06000	LABORATORY	0.133763		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.324135		62.00
65.00	06500	RESPIRATORY THERAPY	0.251696		65.00
66.00	06600	PHYSICAL THERAPY	0.577547		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.153987		67.00
68.00	06800	SPEECH PATHOLOGY	0.488154		68.00
69.00	06900	ELECTROCARDIOLOGY	0.289722		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.206116		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.369868		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.159434		73.00
74.00	07400	RENAL DIALYSIS	0.122851		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000		76.00
76.01	03610	SLEEP LAB	0.133799		76.01
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	DENTAL CLINIC	0.000000		90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0.000000		90.02
90.03	09003	DIABETIC TRAINING	0.000000		90.03
91.00	09100	EMERGENCY	0.186591		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.249859		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet C Part II | Date/Time Prepared: 5/31/2017 9:23 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,604,755	1,008,304	9,596,451	0	0	50.00
51.00	05100	RECOVERY ROOM	665,232	5,508	659,724	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,538,079	470,869	3,067,210	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,219,836	27,852	3,191,984	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,399,194	404,368	6,994,826	0	0	54.00
54.02	05402	ULTRASOUND	712,063	57,415	654,648	0	0	54.02
56.00	05600	RADIOISOTOPE	802,802	11,447	791,355	0	0	56.00
57.00	05700	CT SCAN	1,284,112	71,072	1,213,040	0	0	57.00
58.00	05800	MRI	1,095,227	235,750	859,477	0	0	58.00
60.00	06000	LABORATORY	7,018,446	282,445	6,736,001	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	81,847	38,099	43,748	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,477,973	55,332	1,422,641	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,569,183	903,422	3,665,761	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	479,822	15,265	464,557	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,464,099	21,879	1,442,220	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	9,664,086	764,690	8,899,396	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,323,043	44,581	3,278,462	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,334,662	80,719	6,253,943	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,029,284	173,317	8,855,967	0	0	73.00
74.00	07400	RENAL DIALYSIS	168,995	76,679	92,316	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	398,040	4,162	393,878	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DENTAL CLINIC	0	0	0	0	0	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	90.02
90.03	09003	DIABETIC TRAINING	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	5,143,229	330,118	4,813,111	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,838,707	175,179	2,663,528	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Subtotal (sum of lines 50 thru 199)	81,312,716	5,258,472	76,054,244	0	0	200.00
201.00		Less Observation Beds	2,838,707	175,179	2,663,528	0	0	201.00
202.00		Total (line 200 minus line 201)	78,474,009	5,083,293	73,390,716	0	0	202.00

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

Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet C Part II Date/Time Prepared: 5/31/2017 9:23 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	10,604,755	78,822,380	0.134540		50.00
51.00	05100	RECOVERY ROOM	665,232	4,378,698	0.151925		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,538,079	12,023,900	0.294254		52.00
53.00	05300	ANESTHESIOLOGY	3,219,836	15,155,677	0.212451		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,399,194	10,265,889	0.720755		54.00
54.02	05402	ULTRASOUND	712,063	5,318,107	0.133894		54.02
56.00	05600	RADIOISOTOPE	802,802	6,737,061	0.119162		56.00
57.00	05700	CT SCAN	1,284,112	20,861,189	0.061555		57.00
58.00	05800	MRI	1,095,227	9,260,198	0.118273		58.00
60.00	06000	LABORATORY	7,018,446	52,469,365	0.133763		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	81,847	252,509	0.324135		62.00
65.00	06500	RESPIRATORY THERAPY	1,477,973	5,872,059	0.251696		65.00
66.00	06600	PHYSICAL THERAPY	4,569,183	7,911,364	0.577547		66.00
67.00	06700	OCCUPATIONAL THERAPY	479,822	3,115,996	0.153987		67.00
68.00	06800	SPEECH PATHOLOGY	1,464,099	2,999,255	0.488154		68.00
69.00	06900	ELECTROCARDIOLOGY	9,664,086	33,356,357	0.289722		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,323,043	16,122,166	0.206116		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,334,662	17,126,806	0.369868		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,029,284	56,633,334	0.159434		73.00
74.00	07400	RENAL DIALYSIS	168,995	1,375,611	0.122851		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0.000000		76.00
76.01	03610	SLEEP LAB	398,040	2,974,903	0.133799		76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0.000000		90.00
90.01	09001	DENTAL CLINIC	0	0	0.000000		90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.000000		90.02
90.03	09003	DIABETIC TRAINING	0	0	0.000000		90.03
91.00	09100	EMERGENCY	5,143,229	27,564,237	0.186591		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,838,707	11,361,218	0.249859		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
200.00		Subtotal (sum of lines 50 thru 199)	81,312,716	401,958,279			200.00
201.00		Less Observation Beds	2,838,707	0			201.00
202.00		Total (line 200 minus line 201)	78,474,009	401,958,279			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part I Date/Time Prepared: 5/31/2017 9:23 am

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	1,091,126	0	1,091,126	13,952	78.21	30.00
31.00	INTENSIVE CARE UNIT	446,017		446,017	3,445	129.47	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
43.00	NURSERY	33,869		33,869	1,376	24.61	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	1,571,012		1,571,012	18,773		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	6,631	518,611	30.00
31.00	INTENSIVE CARE UNIT	1,047	135,555	31.00
40.00	SUBPROVIDER - IPF	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30-199)	7,678	654,166	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/31/2017 9:23 am

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	1,008,304	78,822,380	0.012792	11,987,364	153,342	50.00
51.00	05100	RECOVERY ROOM	5,508	4,378,698	0.001258	481,844	606	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	470,869	12,023,900	0.039161	24,869	974	52.00
53.00	05300	ANESTHESIOLOGY	27,852	15,155,677	0.001838	2,093,452	3,848	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	404,368	10,265,889	0.039389	1,095,226	43,140	54.00
54.02	05402	ULTRASOUND	57,415	5,318,107	0.010796	413,076	4,460	54.02
56.00	05600	RADIOISOTOPE	11,447	6,737,061	0.001699	536,983	912	56.00
57.00	05700	CT SCAN	71,072	20,861,189	0.003407	2,948,482	10,045	57.00
58.00	05800	MRI	235,750	9,260,198	0.025458	573,140	14,591	58.00
60.00	06000	LABORATORY	282,445	52,469,365	0.005383	8,363,461	45,021	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	38,099	252,509	0.150882	7,910	1,193	62.00
65.00	06500	RESPIRATORY THERAPY	55,332	5,872,059	0.009423	2,254,956	21,248	65.00
66.00	06600	PHYSICAL THERAPY	903,422	7,911,364	0.114193	725,000	82,790	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,265	3,115,996	0.004899	935,117	4,581	67.00
68.00	06800	SPEECH PATHOLOGY	21,879	2,999,255	0.007295	280,631	2,047	68.00
69.00	06900	ELECTROCARDIOLOGY	764,690	33,356,357	0.022925	4,509,133	103,372	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	44,581	16,122,166	0.002765	3,922,981	10,847	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	80,719	17,126,806	0.004713	4,550,151	21,445	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	173,317	56,633,334	0.003060	13,832,793	42,328	73.00
74.00	07400	RENAL DIALYSIS	76,679	1,375,611	0.055742	868,997	48,440	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	4,162	2,974,903	0.001399	109,635	153	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	DENTAL CLINIC	0	0	0.000000	0	0	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.000000	0	0	90.02
90.03	09003	DIABETIC TRAINING	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	330,118	27,564,237	0.011976	2,651,575	31,755	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	175,179	11,361,218	0.015419	411,891	6,351	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	5,258,472	401,958,279		63,578,667	653,489	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 5/31/2017 9:23 am

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
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0			0	44.00
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	13,952	0.00	6,631	0		30.00
31.00	03100	INTENSIVE CARE UNIT	3,445	0.00	1,047	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	0.00	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0		41.00
43.00	04300	NURSERY	1,376	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	18,773		7,678	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/31/2017 9:23 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.02	05402	ULTRASOUND	0	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DENTAL CLINIC	0	0	0	0	0	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	90.02
90.03	09003	DIABETIC TRAINING	0	0	0	0	0	90.03
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/31/2017 9:23 am

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	78,822,380	0.000000	0.000000	11,987,364	50.00
51.00	05100	RECOVERY ROOM	0	4,378,698	0.000000	0.000000	481,844	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	12,023,900	0.000000	0.000000	24,869	52.00
53.00	05300	ANESTHESIOLOGY	0	15,155,677	0.000000	0.000000	2,093,452	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,265,889	0.000000	0.000000	1,095,226	54.00
54.02	05402	ULTRASOUND	0	5,318,107	0.000000	0.000000	413,076	54.02
56.00	05600	RADIOISOTOPE	0	6,737,061	0.000000	0.000000	536,983	56.00
57.00	05700	CT SCAN	0	20,861,189	0.000000	0.000000	2,948,482	57.00
58.00	05800	MRI	0	9,260,198	0.000000	0.000000	573,140	58.00
60.00	06000	LABORATORY	0	52,469,365	0.000000	0.000000	8,363,461	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	252,509	0.000000	0.000000	7,910	62.00
65.00	06500	RESPIRATORY THERAPY	0	5,872,059	0.000000	0.000000	2,254,956	65.00
66.00	06600	PHYSICAL THERAPY	0	7,911,364	0.000000	0.000000	725,000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,115,996	0.000000	0.000000	935,117	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,999,255	0.000000	0.000000	280,631	68.00
69.00	06900	ELECTROCARDIOLOGY	0	33,356,357	0.000000	0.000000	4,509,133	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	16,122,166	0.000000	0.000000	3,922,981	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	17,126,806	0.000000	0.000000	4,550,151	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	56,633,334	0.000000	0.000000	13,832,793	73.00
74.00	07400	RENAL DIALYSIS	0	1,375,611	0.000000	0.000000	868,997	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	2,974,903	0.000000	0.000000	109,635	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	DENTAL CLINIC	0	0	0.000000	0.000000	0	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.000000	0.000000	0	90.02
90.03	09003	DIABETIC TRAINING	0	0	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	27,564,237	0.000000	0.000000	2,651,575	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	11,361,218	0.000000	0.000000	411,891	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	401,958,279			63,578,667	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/31/2017 9:23 am

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	14,328,340	0		50.00
51.00	05100	RECOVERY ROOM	0	756,995	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	3,118,844	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,050,477	0		54.00
54.02	05402	ULTRASOUND	0	692,151	0		54.02
56.00	05600	RADIOISOTOPE	0	2,712,026	0		56.00
57.00	05700	CT SCAN	0	5,069,651	0		57.00
58.00	05800	MRI	0	2,450,896	0		58.00
60.00	06000	LABORATORY	0	4,532,583	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	110,112	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	278,878	0		65.00
66.00	06600	PHYSICAL THERAPY	0	49,627	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	45,492	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	20,423	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,036,830	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,002,801	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,241,528	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,088,945	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0		76.00
76.01	03610	SLEEP LAB	0	708,686	0		76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	DENTAL CLINIC	0	0	0		90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0		90.02
90.03	09003	DIABETIC TRAINING	0	0	0		90.03
91.00	09100	EMERGENCY	0	4,698,164	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,182,783	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	68,176,232	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/31/2017 9:23 am

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	0.134540	14,328,340	0	0	1,927,735	50.00
51.00	05100	RECOVERY ROOM	0.151925	756,995	0	0	115,006	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.294254	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.212451	3,118,844	0	0	662,602	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.720755	2,050,477	0	0	1,477,892	54.00
54.02	05402	ULTRASOUND	0.133894	692,151	0	0	92,675	54.02
56.00	05600	RADIOISOTOPE	0.119162	2,712,026	0	0	323,170	56.00
57.00	05700	CT SCAN	0.061555	5,069,651	0	0	312,062	57.00
58.00	05800	MRI	0.118273	2,450,896	0	0	289,875	58.00
60.00	06000	LABORATORY	0.133763	4,532,583	167	0	606,292	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.324135	110,112	0	0	35,691	62.00
65.00	06500	RESPIRATORY THERAPY	0.251696	278,878	0	0	70,192	65.00
66.00	06600	PHYSICAL THERAPY	0.577547	49,627	0	0	28,662	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.153987	45,492	0	0	7,005	67.00
68.00	06800	SPEECH PATHOLOGY	0.488154	20,423	0	0	9,970	68.00
69.00	06900	ELECTROCARDIOLOGY	0.289722	10,036,830	0	0	2,907,890	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.206116	4,002,801	0	0	825,041	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.369868	3,241,528	0	0	1,198,937	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.159434	8,088,945	99,470	0	1,289,653	73.00
74.00	07400	RENAL DIALYSIS	0.122851	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.133799	708,686	0	0	94,821	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	DENTAL CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	0	0	90.02
90.03	09003	DIABETIC TRAINING	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.186591	4,698,164	0	0	876,635	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.249859	1,182,783	0	0	295,529	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		68,176,232	99,637	0	13,447,335	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		68,176,232	99,637	0	13,447,335	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/31/2017 9:23 am

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
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.02	05402	ULTRASOUND	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	22	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,859	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	76.00
76.01	03610	SLEEP LAB	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	DENTAL CLINIC	0	0	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	90.02
90.03	09003	DIABETIC TRAINING	0	0	90.03
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	15,881	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	15,881	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part I Date/Time Prepared: 5/31/2017 9:23 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,091,126	0	1,091,126	13,952	78.21	30.00
31.00	INTENSIVE CARE UNIT	446,017		446,017	3,445	129.47	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
43.00	NURSERY	33,869		33,869	1,376	24.61	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	1,571,012		1,571,012	18,773		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	2,097	164,006	30.00
31.00	INTENSIVE CARE UNIT	537	69,525	31.00
40.00	SUBPROVIDER - IPF	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
43.00	NURSERY	918	22,592	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30-199)	3,552	256,123	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/31/2017 9:23 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,008,304	78,822,380	0.012792	6,051,238	77,407	50.00
51.00	05100	RECOVERY ROOM	5,508	4,378,698	0.001258	206,034	259	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	470,869	12,023,900	0.039161	1,585,762	62,100	52.00
53.00	05300	ANESTHESIOLOGY	27,852	15,155,677	0.001838	931,827	1,713	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	404,368	10,265,889	0.039389	252,141	9,932	54.00
54.02	05402	ULTRASOUND	57,415	5,318,107	0.010796	117,164	1,265	54.02
56.00	05600	RADIOISOTOPE	11,447	6,737,061	0.001699	125,377	213	56.00
57.00	05700	CT SCAN	71,072	20,861,189	0.003407	609,632	2,077	57.00
58.00	05800	MRI	235,750	9,260,198	0.025458	139,905	3,562	58.00
60.00	06000	LABORATORY	282,445	52,469,365	0.005383	2,700,898	14,539	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	38,099	252,509	0.150882	1,437	217	62.00
65.00	06500	RESPIRATORY THERAPY	55,332	5,872,059	0.009423	641,875	6,048	65.00
66.00	06600	PHYSICAL THERAPY	903,422	7,911,364	0.114193	110,640	12,634	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,265	3,115,996	0.004899	148,691	728	67.00
68.00	06800	SPEECH PATHOLOGY	21,879	2,999,255	0.007295	28,633	209	68.00
69.00	06900	ELECTROCARDIOLOGY	764,690	33,356,357	0.022925	904,163	20,728	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	44,581	16,122,166	0.002765	1,342,670	3,712	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	80,719	17,126,806	0.004713	1,536,325	7,241	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	173,317	56,633,334	0.003060	4,874,736	14,917	73.00
74.00	07400	RENAL DIALYSIS	76,679	1,375,611	0.055742	84,116	4,689	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	4,162	2,974,903	0.001399	30,847	43	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	DENTAL CLINIC	0	0	0.000000	0	0	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.000000	0	0	90.02
90.03	09003	DIABETIC TRAINING	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	330,118	27,564,237	0.011976	616,917	7,388	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	175,179	11,361,218	0.015419	280,676	4,328	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	5,258,472	401,958,279		23,321,704	255,949	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 5/31/2017 9:23 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0			0	44.00
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	13,952	0.00	2,097	0		30.00
31.00	03100	INTENSIVE CARE UNIT	3,445	0.00	537	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	0.00	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0		41.00
43.00	04300	NURSERY	1,376	0.00	918	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	18,773		3,552	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/31/2017 9:23 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.02	05402	ULTRASOUND	0	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DENTAL CLINIC	0	0	0	0	0	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	90.02
90.03	09003	DIABETIC TRAINING	0	0	0	0	0	90.03
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/31/2017 9:23 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	78,822,380	0.000000	0.000000	6,051,238	50.00
51.00	05100	RECOVERY ROOM	0	4,378,698	0.000000	0.000000	206,034	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	12,023,900	0.000000	0.000000	1,585,762	52.00
53.00	05300	ANESTHESIOLOGY	0	15,155,677	0.000000	0.000000	931,827	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,265,889	0.000000	0.000000	252,141	54.00
54.02	05402	ULTRASOUND	0	5,318,107	0.000000	0.000000	117,164	54.02
56.00	05600	RADIOISOTOPE	0	6,737,061	0.000000	0.000000	125,377	56.00
57.00	05700	CT SCAN	0	20,861,189	0.000000	0.000000	609,632	57.00
58.00	05800	MRI	0	9,260,198	0.000000	0.000000	139,905	58.00
60.00	06000	LABORATORY	0	52,469,365	0.000000	0.000000	2,700,898	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	252,509	0.000000	0.000000	1,437	62.00
65.00	06500	RESPIRATORY THERAPY	0	5,872,059	0.000000	0.000000	641,875	65.00
66.00	06600	PHYSICAL THERAPY	0	7,911,364	0.000000	0.000000	110,640	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,115,996	0.000000	0.000000	148,691	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,999,255	0.000000	0.000000	28,633	68.00
69.00	06900	ELECTROCARDIOLOGY	0	33,356,357	0.000000	0.000000	904,163	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	16,122,166	0.000000	0.000000	1,342,670	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	17,126,806	0.000000	0.000000	1,536,325	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	56,633,334	0.000000	0.000000	4,874,736	73.00
74.00	07400	RENAL DIALYSIS	0	1,375,611	0.000000	0.000000	84,116	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	2,974,903	0.000000	0.000000	30,847	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	DENTAL CLINIC	0	0	0.000000	0.000000	0	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.000000	0.000000	0	90.02
90.03	09003	DIABETIC TRAINING	0	0	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	27,564,237	0.000000	0.000000	616,917	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	11,361,218	0.000000	0.000000	280,676	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	401,958,279			23,321,704	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/31/2017 9:23 am

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.02	05402	ULTRASOUND	0	0	0		54.02
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	DENTAL CLINIC	0	0	0		90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0		90.02
90.03	09003	DIABETIC TRAINING	0	0	0		90.03
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/31/2017 9:23 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.134540	0	10,815,888	0	0	50.00
51.00	05100	RECOVERY ROOM	0.151925	0	857,061	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.294254	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.212451	0	2,265,382	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.720755	0	1,597,019	0	0	54.00
54.02	05402	ULTRASOUND	0.133894	0	1,448,761	0	0	54.02
56.00	05600	RADIOISOTOPE	0.119162	0	665,379	0	0	56.00
57.00	05700	CT SCAN	0.061555	0	3,239,532	0	0	57.00
58.00	05800	MRI	0.118273	0	1,635,228	0	0	58.00
60.00	06000	LABORATORY	0.133763	0	7,983,455	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.324135	0	36,670	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.251696	0	243,089	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.577547	0	1,199,649	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.153987	0	1,209,208	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.488154	0	669,657	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.289722	0	3,287,041	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.206116	0	1,411,880	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.369868	0	1,180,600	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.159434	0	5,815,814	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.122851	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.133799	0	560,856	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	DENTAL CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	0	0	90.02
90.03	09003	DIABETIC TRAINING	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.186591	0	7,794,976	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.249859	0	1,885,217	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	55,802,362	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	55,802,362	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/31/2017 9:23 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,455,170	0		50.00
51.00	05100	RECOVERY ROOM	130,209	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	481,283	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,151,059	0		54.00
54.02	05402	ULTRASOUND	193,980	0		54.02
56.00	05600	RADIOISOTOPE	79,288	0		56.00
57.00	05700	CT SCAN	199,409	0		57.00
58.00	05800	MRI	193,403	0		58.00
60.00	06000	LABORATORY	1,067,891	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	11,886	0		62.00
65.00	06500	RESPIRATORY THERAPY	61,185	0		65.00
66.00	06600	PHYSICAL THERAPY	692,854	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	186,202	0		67.00
68.00	06800	SPEECH PATHOLOGY	326,896	0		68.00
69.00	06900	ELECTROCARDIOLOGY	952,328	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	291,011	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	436,666	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	927,238	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY-OTHER	0	0		76.00
76.01	03610	SLEEP LAB	75,042	0		76.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	DENTAL CLINIC	0	0		90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0	0		90.02
90.03	09003	DIABETIC TRAINING	0	0		90.03
91.00	09100	EMERGENCY	1,454,472	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	471,038	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	10,838,510	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	10,838,510	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/31/2017 9:23 am

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)	13,952	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,952	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)	11,712	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)	6,631	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)	17,681,087	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)	17,681,087	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)	17,681,087	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)	1,267.28	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	8,403,334	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)	8,403,334	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/31/2017 9:23 am

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	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	6,003,549	3,445	1,742.68	1,047	1,824,586	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)	12,407,041	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	22,634,961	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)	654,166	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	653,489	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,307,655	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	21,327,306	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)	2,240	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,267.28	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,838,707	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/31/2017 9:23 am

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	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	1,091,126	17,681,087	0.061711	2,838,707	175,179	90.00
91.00	Nursing School cost	0	17,681,087	0.000000	2,838,707	0	91.00
92.00	Allied health cost	0	17,681,087	0.000000	2,838,707	0	92.00
93.00	All other Medical Education	0	17,681,087	0.000000	2,838,707	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/31/2017 9:23 am

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	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)	13,952	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,952	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)	11,712	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)	2,097	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)	1,376	15.00
16.00	Nursery days (title V or XIX only)	918	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)	17,681,087	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)	17,681,087	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)	17,681,087	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)	1,267.28	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,657,486	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,657,486	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/31/2017 9:23 am

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	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)	76,451	1,376	55.56	918	51,004	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	6,003,549	3,445	1,742.68	537	935,819	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)	4,484,369	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,128,678	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)	256,123	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	255,949	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	512,072	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,616,606	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)	2,240	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,267.28	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,838,707	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/31/2017 9:23 am

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	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	1,091,126	17,681,087	0.061711	2,838,707	175,179	90.00
91.00	Nursing School cost	0	17,681,087	0.000000	2,838,707	0	91.00
92.00	Allied health cost	0	17,681,087	0.000000	2,838,707	0	92.00
93.00	All other Medical Education	0	17,681,087	0.000000	2,838,707	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/31/2017 9:23 am

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		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		13,971,418		30.00
31.00	03100	INTENSIVE CARE UNIT		3,580,446		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.134540	11,987,364	1,612,780	50.00
51.00	05100	RECOVERY ROOM	0.151925	481,844	73,204	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.294254	24,869	7,318	52.00
53.00	05300	ANESTHESIOLOGY	0.212451	2,093,452	444,756	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.720755	1,095,226	789,390	54.00
54.02	05402	ULTRASOUND	0.133894	413,076	55,308	54.02
56.00	05600	RADIOISOTOPE	0.119162	536,983	63,988	56.00
57.00	05700	CT SCAN	0.061555	2,948,482	181,494	57.00
58.00	05800	MRI	0.118273	573,140	67,787	58.00
60.00	06000	LABORATORY	0.133763	8,363,461	1,118,722	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.324135	7,910	2,564	62.00
65.00	06500	RESPIRATORY THERAPY	0.251696	2,254,956	567,563	65.00
66.00	06600	PHYSICAL THERAPY	0.577547	725,000	418,722	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.153987	935,117	143,996	67.00
68.00	06800	SPEECH PATHOLOGY	0.488154	280,631	136,991	68.00
69.00	06900	ELECTROCARDIOLOGY	0.289722	4,509,133	1,306,395	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.206116	3,922,981	808,589	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.369868	4,550,151	1,682,955	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.159434	13,832,793	2,205,418	73.00
74.00	07400	RENAL DIALYSIS	0.122851	868,997	106,757	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.133799	109,635	14,669	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	DENTAL CLINIC	0.000000	0	0	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	90.02
90.03	09003	DIABETIC TRAINING	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.186591	2,651,575	494,760	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.249859	411,891	102,915	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		63,578,667	12,407,041	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)		63,578,667		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/31/2017 9:23 am

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		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		3,188,207		30.00
31.00	03100	INTENSIVE CARE UNIT		1,129,386		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		1,117,095		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.134540	6,051,238	814,134	50.00
51.00	05100	RECOVERY ROOM	0.151925	206,034	31,302	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.294254	1,585,762	466,617	52.00
53.00	05300	ANESTHESIOLOGY	0.212451	931,827	197,968	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.720755	252,141	181,732	54.00
54.02	05402	ULTRASOUND	0.133894	117,164	15,688	54.02
56.00	05600	RADIOISOTOPE	0.119162	125,377	14,940	56.00
57.00	05700	CT SCAN	0.061555	609,632	37,526	57.00
58.00	05800	MRI	0.118273	139,905	16,547	58.00
60.00	06000	LABORATORY	0.133763	2,700,898	361,280	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.324135	1,437	466	62.00
65.00	06500	RESPIRATORY THERAPY	0.251696	641,875	161,557	65.00
66.00	06600	PHYSICAL THERAPY	0.577547	110,640	63,900	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.153987	148,691	22,896	67.00
68.00	06800	SPEECH PATHOLOGY	0.488154	28,633	13,977	68.00
69.00	06900	ELECTROCARDIOLOGY	0.289722	904,163	261,956	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.206116	1,342,670	276,746	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.369868	1,536,325	568,237	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.159434	4,874,736	777,199	73.00
74.00	07400	RENAL DIALYSIS	0.122851	84,116	10,334	74.00
76.00	03950	OTHER ANCILLARY-OTHER	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.133799	30,847	4,127	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	DENTAL CLINIC	0.000000	0	0	90.01
90.02	09002	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	90.02
90.03	09003	DIABETIC TRAINING	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.186591	616,917	115,111	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.249859	280,676	70,129	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		23,321,704	4,484,369	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		23,321,704		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	Period: From 03/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/31/2017 9:23 am
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		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)	11,362,928	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,787,643	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)	925,038	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	121.68	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)	3.72	30.00
31.00	Percentage of Medicaid patient days (see instructions)	21.48	31.00
32.00	Sum of lines 30 and 31	25.20	32.00
33.00	Allowable disproportionate share percentage (see instructions)	10.01	33.00
34.00	Disproportionate share adjustment (see instructions)	379,143	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	Period: From 03/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/31/2017 9:23 am
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		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)	0.000131489	0.000124100	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	842,340	741,806	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	492,515	186,976	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	679,491		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)	17,134,243		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)	17,134,243	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,439,404	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	1,036	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)	18,574,683	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	18,574,683	61.00
62.00	Deductibles billed to program beneficiaries	1,665,384	62.00
63.00	Coinsurance billed to program beneficiaries	67,942	63.00
64.00	Allowable bad debts (see instructions)	22,105	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	14,368	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	22,105	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	16,855,725	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)	-19,761	70.93
70.94	HRR adjustment amount (see instructions)	-129,425	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	Period: From 03/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/31/2017 9:23 am
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		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)		16,706,539	71.00
71.01	Sequestration adjustment (see instructions)		334,131	71.01
72.00	Interim payments		16,241,169	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)		131,239	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,373,936	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	Period: From 03/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/31/2017 9:23 am
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	15,881	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	13,447,335	2.00
3.00	PPS payments	11,291,841	3.00
4.00	Outlier payment (see instructions)	140,697	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)	15,881	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	99,637	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)	99,637	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)	99,637	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	83,756	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)	15,881	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)	11,432,538	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	1,172	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,126,959	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)	9,320,288	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)	9,320,288	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	9,320,288	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)	121,793	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	79,165	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	121,793	36.00
37.00	Subtotal (see instructions)	9,399,453	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)	9,399,453	40.00
40.01	Sequestration adjustment (see instructions)	187,989	40.01
41.00	Interim payments	9,124,861	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	86,603	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: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2017 9:23 am

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		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		16,241,169		9,124,861	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	0	0	3.01
3.02		0	0	0	0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	0	0	0	0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		16,241,169		9,124,861	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		131,239		86,603	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		16,372,408		9,211,464	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: 15-0006	Period: From 03/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/31/2017 9:23 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	Period: From 03/01/2016 To 12/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 5/31/2017 9:23 am
	Title XIX	Hospital	PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		10,838,510	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	10,838,510	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	10,838,510	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	23,321,704	55,802,362	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)	23,321,704	55,802,362	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)	23,321,704	55,802,362	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	23,321,704	44,963,852	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	10,838,510	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	10,838,510	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	10,838,510	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	10,838,510	36.00
37.00	OTHER ADJUSTMENTS-ADJUSTMENT TO $0	0	-10,838,510	37.00
38.00	Subtotal (line 36 ± line 37)	0	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)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	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: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 5/31/2017 9:23 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-1,875,676	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	39,159,916	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,529,290	0	0	0	6.00
7.00	Inventory	2,545,241	0	0	0	7.00
8.00	Prepaid expenses	1,075,780	0	0	0	8.00
9.00	Other current assets	1,427,569	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)	32,803,540	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,209,970	0	0	0	12.00
13.00	Land improvements	1,261,034	0	0	0	13.00
14.00	Accumulated depreciation	-1,201,513	0	0	0	14.00
15.00	Buildings	32,536,179	0	0	0	15.00
16.00	Accumulated depreciation	-899,380	0	0	0	16.00
17.00	Leasehold improvements	3,504,874	0	0	0	17.00
18.00	Accumulated depreciation	-1,969,414	0	0	0	18.00
19.00	Fixed equipment	988,233	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	24,060,775	0	0	0	23.00
24.00	Accumulated depreciation	-5,913,294	0	0	0	24.00
25.00	Minor equipment depreciable	-871,854	0	0	0	25.00
26.00	Accumulated depreciation	-4,929	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)	52,700,681	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	58,430,152	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	58,430,152	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	143,934,373	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,821,087	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,466,019	0	0	0	38.00
39.00	Payroll taxes payable	480,927	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	96,304,216	0	0	0	43.00
44.00	Other current liabilities	391,636	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	108,463,885	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	26,257,994	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	26,257,994	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	134,721,879	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	9,212,494				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)	9,212,494	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	143,934,373	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 5/31/2017 9:23 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,212,494				2.00
3.00	Total (sum of line 1 and line 2)		9,212,494		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		9,212,494		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)		9,212,494		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0006 | Period: From 03/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/31/2017 9:23 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	18,845,939		18,845,939	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	0		0	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	0		0	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)	18,845,939		18,845,939	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	7,300,166		7,300,166	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)	7,300,166		7,300,166	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	26,146,105		26,146,105	17.00
18.00	Ancillary services	143,968,655	0	143,968,655	18.00
19.00	Outpatient services	0	257,989,624	257,989,624	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	170,114,760	257,989,624	428,104,384	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		123,849,230		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)		123,849,230		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0006	Period: From 03/01/2016 To 12/31/2016	Worksheet G-3 Date/Time Prepared: 5/31/2017 9:23 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	428,104,384	1.00
2.00	Less contractual allowances and discounts on patients' accounts	298,256,660	2.00
3.00	Net patient revenues (line 1 minus line 2)	129,847,724	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	123,849,230	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,998,494	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	3,214,015	24.00
25.00	Total other income (sum of lines 6-24)	3,214,015	25.00
26.00	Total (line 5 plus line 25)	9,212,509	26.00
27.00	OTHER EXPENSES	15	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	15	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	9,212,494	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0006	Period: From 03/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 5/31/2017 9:23 am
	Title XVIII	Hospital	PPS

			1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,216,855	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	158,907	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)	49.53	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)	3.72	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	21.48	8.00
9.00	Sum of lines 7 and 8	25.20	9.00
10.00	Allowable disproportionate share percentage (see instructions)	5.23	10.00
11.00	Disproportionate share adjustment (see instructions)	63,642	11.00
12.00	Total prospective capital payments (see instructions)	1,439,404	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