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: 15-0072	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/25/2017 9:37 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/25/2017 Time: 9:37 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 MEMORIAL HOSPITAL LOGANSPORT (15-0072) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-5,319	138,678	0	-211,993	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I						4.00
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	-5,319	138,678	0	-211,993	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2017 9:36 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1101 MICHIGAN AVENUE	PO Box:			1.00
2.00	City: LOGANSPORT	State: IN	Zip Code: 46947-	County: CASS	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	MEMORIAL HOSPITAL LOGANSPORT	150072	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SWING BED - SNF	15U072	99915		05/14/2008	N	P	P	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2016	12/31/2016	20.00
21.00	Type of Control (see instructions)	9		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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.	389	0	0	0	1,359	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: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2017 9:36 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1		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.	01/01/2016	12/31/2016	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2017 9:36 am

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

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2017 9:36 am

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	575,958	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2017 9:36 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)	N		140.00

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0072	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/25/2017 9:36 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)	01/01/2016	12/31/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 5/25/2017 9:36 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/12/2017	Y	04/12/2017
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 5/25/2017 9:36 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.	N	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?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MICHAEL	ALESSANDRINI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7959	MALESSANDRINI@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0072	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/25/2017 9:36 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.	SENIOR 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: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/25/2017 9:36 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	77	28,182	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)		77	28,182	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,196	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		83	30,378	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	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)		83				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: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2017 9:36 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)	2,094	223	4,769			1.00
2.00	HMO and other (see instructions)	147	1,359				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)	2,094	223	4,769			7.00
8.00	INTENSIVE CARE UNIT	229	0	442			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		166	1,096			13.00
14.00	Total (see instructions)	2,323	389	6,307	0.00	516.90	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	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	516.90	27.00
28.00	Observation Bed Days		21	1,329			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: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2017 9:36 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	686	165	1,693	1.00
2.00	HMO and other (see instructions)			44	555		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	686	165	1,693	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0		0	0	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: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 5/25/2017 9:36 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	31,318,222	0	31,318,222	1,066,982.00	29.35	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		105,208	0	105,208	865.00	121.63	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		4,058,065	0	4,058,065	33,365.00	121.63	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)		7,397,085	0	7,397,085	172,187.00	42.96	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		238,830	0	238,830	2,382.00	100.26	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,054,995	0	7,054,995			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,411,604	0	1,411,604			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		7,091	0	7,091			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		273,526	0	273,526			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	299,513	0	299,513	10,328.00	29.00	26.00
27.00	Administrative & General	5.00	3,648,348	0	3,648,348	146,328.00	24.93	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 5/25/2017 9:36 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.)		116,314	0	116,314	825.00	140.99	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	548,920	0	548,920	20,344.00	26.98	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	582,188	0	582,188	48,099.00	12.10	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	808,804	-613,614	195,190	16,926.00	11.53	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	613,614	613,614	44,866.00	13.68	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	498,306	0	498,306	11,911.00	41.84	38.00
39.00	Central Services and Supply	14.00	199,627	0	199,627	12,223.00	16.33	39.00
40.00	Pharmacy	15.00	442,962	0	442,962	12,847.00	34.48	40.00
41.00	Medical Records & Medical Records Library	16.00	599,401	0	599,401	30,255.00	19.81	41.00
42.00	Social Service	17.00	327,002	0	327,002	11,369.00	28.76	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part III Date/Time Prepared: 5/25/2017 9:36 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)		27,376,471	0	27,376,471	1,034,442.00	26.46	1.00
2.00	Excluded area salaries (see instructions)		7,397,085	0	7,397,085	172,187.00	42.96	2.00
3.00	Subtotal salaries (line 1 minus line 2)		19,979,386	0	19,979,386	862,255.00	23.17	3.00
4.00	Subtotal other wages & related costs (see inst.)		238,830	0	238,830	2,382.00	100.26	4.00
5.00	Subtotal wage-related costs (see inst.)		7,062,086	0	7,062,086	0.00	35.35	5.00
6.00	Total (sum of lines 3 thru 5)		27,280,302	0	27,280,302	864,637.00	31.55	6.00
7.00	Total overhead cost (see instructions)		8,071,385	0	8,071,385	366,321.00	22.03	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part IV Date/Time Prepared: 5/25/2017 9:36 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	302,043	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)	5,656,040	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	134,247	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	43,941	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	257,341	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	235,146	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	2,028,707	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	52,382	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	37,369	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,747,216	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part V Date/Time Prepared: 5/25/2017 9:36 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	0	8,747,216	1.00
2.00	Hospital	0	8,747,216	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	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			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 5/25/2017 9:36 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)	0.307353	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,086,511	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	29,309,613	6.00
7.00	Medicaid cost (line 1 times line 6)	9,008,397	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,921,886	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,921,886	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)	1,630,892	0	1,630,892	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	501,260	0	501,260	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	501,260	0	501,260	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)	7,303,985	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	209,375	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	7,094,610	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,180,550	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,681,810	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,603,696	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/25/2017 9:36 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		4,274,990	4,274,990	-248,518	4,026,472	1.00
1.01	00101	MOB		226,553	226,553	0	226,553	1.01
1.02	00102	OPS		147,326	147,326	0	147,326	1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	299,513	9,399,160	9,698,673	0	9,698,673	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,648,348	4,548,092	8,196,440	525,391	8,721,831	5.00
7.00	00700	OPERATION OF PLANT	548,920	1,918,773	2,467,693	0	2,467,693	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	225,979	225,979	0	225,979	8.00
9.00	00900	HOUSEKEEPING	582,188	195,179	777,367	0	777,367	9.00
10.00	01000	DIETARY	808,804	280,737	1,089,541	-826,600	262,941	10.00
11.00	01100	CAFETERIA	0	0	0	826,600	826,600	11.00
13.00	01300	NURSING ADMINISTRATION	498,306	12,338	510,644	0	510,644	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	199,627	2,280,348	2,479,975	-976,870	1,503,105	14.00
15.00	01500	PHARMACY	442,962	1,802,975	2,245,937	0	2,245,937	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	599,401	161,815	761,216	0	761,216	16.00
17.00	01700	SOCIAL SERVICE	327,002	41,504	368,506	0	368,506	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,711,356	332,789	3,044,145	-850,997	2,193,148	30.00
31.00	03100	INTENSIVE CARE UNIT	565,873	49,267	615,140	0	615,140	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	26,054	26,054	262,513	288,567	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,624,537	654,199	2,278,736	0	2,278,736	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	98,580	7,578	106,158	588,484	694,642	52.00
53.00	05300	ANESTHESIOLOGY	0	741,058	741,058	0	741,058	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,091,372	858,230	1,949,602	0	1,949,602	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	2,647,994	2,647,994	0	2,647,994	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	173,817	173,817	0	173,817	63.00
65.00	06500	RESPIRATORY THERAPY	541,364	108,975	650,339	0	650,339	65.00
66.00	06600	PHYSICAL THERAPY	45,545	761,295	806,840	0	806,840	66.00
69.00	06900	ELECTROCARDIOLOGY	280,804	111,336	392,140	0	392,140	69.00
69.01	06901	CARDIAC REHAB	119,643	18,230	137,873	0	137,873	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	976,870	976,870	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	202,128	304,837	506,965	0	506,965	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,150,153	1,760,725	8,910,878	-135,930	8,774,948	90.00
91.00	09100	EMERGENCY	1,534,711	1,224,853	2,759,564	0	2,759,564	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)	23,921,137	35,297,006	59,218,143	140,943	59,359,086	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	6,471	6,471	0	6,471	194.00
194.01	07951	MOB	0	-2,997	-2,997	0	-2,997	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	547,014	290,118	837,132	-107	837,025	194.04
194.05	07955	PHYSICIANS OFFICE	6,682,156	3,259,624	9,941,780	-132,556	9,809,224	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	166,476	20,929	187,405	-8,280	179,125	194.07
194.08	07958	OPS	0	0	0	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	1,439	18,949	20,388	0	20,388	194.09
200.00		TOTAL (SUM OF LINES 118-199)	31,318,222	38,890,100	70,208,322	0	70,208,322	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/25/2017 9:36 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-30,566	3,995,906		1.00
1.01	00101	MOB	0	226,553		1.01
1.02	00102	OPS	0	147,326		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,796	9,694,877		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,112,018	6,609,813		5.00
7.00	00700	OPERATION OF PLANT	-11,485	2,456,208		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	225,979		8.00
9.00	00900	HOUSEKEEPING	0	777,367		9.00
10.00	01000	DIETARY	-25,419	237,522		10.00
11.00	01100	CAFETERIA	-341,739	484,861		11.00
13.00	01300	NURSING ADMINISTRATION	0	510,644		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,503,105		14.00
15.00	01500	PHARMACY	0	2,245,937		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-28,005	733,211		16.00
17.00	01700	SOCIAL SERVICE	0	368,506		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,193,148		30.00
31.00	03100	INTENSIVE CARE UNIT	0	615,140		31.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	288,567		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,278,736		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	694,642		52.00
53.00	05300	ANESTHESIOLOGY	-699,585	41,473		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,949,602		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	2,647,994		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	173,817		63.00
65.00	06500	RESPIRATORY THERAPY	0	650,339		65.00
66.00	06600	PHYSICAL THERAPY	0	806,840		66.00
69.00	06900	ELECTROCARDIOLOGY	0	392,140		69.00
69.01	06901	CARDIAC REHAB	0	137,873		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	976,870		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	506,965		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-4,703,035	4,071,913		90.00
91.00	09100	EMERGENCY	-1,001,952	1,757,612		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-8,957,600	50,401,486		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	FOUNDATION	0	6,471		194.00
194.01	07951	MOB	0	-2,997		194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0		194.02
194.03	07953	PIH	0	0		194.03
194.04	07954	HEALTH COMPANIES	0	837,025		194.04
194.05	07955	PHYSICIANS OFFICE	0	9,809,224		194.05
194.06	07956	THE ARBORS	0	0		194.06
194.07	07957	PAIN MANAGEMENT	0	179,125		194.07
194.08	07958	OPS	0	0		194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	20,388		194.09
200.00		TOTAL (SUM OF LINES 118-199)	-8,957,600	61,250,722		200.00

RECLASSIFICATIONS | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/25/2017 9:36 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	613,614	212,986		1.00
	0		613,614	212,986		
	B - OB RECLASS					
1.00	NURSERY	43.00	241,016	21,497		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	481,597	106,887		2.00
	0		722,613	128,384		
	C - MALPRACTICE INS. RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	525,391		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	0		0	525,391		
	D - IMPLANT EXPENSE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	976,870		1.00
	0		0	976,870		
500.00	Grand Total: Increases		1,336,227	1,843,631		500.00

RECLASSIFICATIONS | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/25/2017 9:36 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	613,614	212,986	0		1.00
	0		613,614	212,986			
	B - OB RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	722,613	128,384	0		1.00
2.00		0.00	0	0	0		2.00
	0		722,613	128,384			
	C - MALPRACTICE INS. RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	248,518	12		1.00
2.00	CLINIC	90.00	0	135,930	0		2.00
3.00	HEALTH COMPANIES	194.04	0	107	0		3.00
4.00	PHYSICIANS OFFICE	194.05	0	132,556	0		4.00
5.00	PAIN MANAGEMENT	194.07	0	8,280	0		5.00
	0		0	525,391			
	D - IMPLANT EXPENSE RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	976,870	0		1.00
	0		0	976,870			
500.00	Grand Total: Decreases		1,336,227	1,843,631			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 5/25/2017 9:36 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	205,783	0	0	0	0	1.00
2.00	Land Improvements	443,093	123,147	0	123,147	0	2.00
3.00	Buildings and Fixtures	58,930,076	1,440,960	0	1,440,960	0	3.00
4.00	Building Improvements	1,746,094	2,982,613	0	2,982,613	2,126,442	4.00
5.00	Fixed Equipment	36,484,300	2,612,380	0	2,612,380	22,342	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)	97,809,346	7,159,100	0	7,159,100	2,148,784	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	97,809,346	7,159,100	0	7,159,100	2,148,784	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	205,783	0	1.00
2.00	Land Improvements	566,240	0	2.00
3.00	Buildings and Fixtures	60,371,036	0	3.00
4.00	Building Improvements	2,602,265	0	4.00
5.00	Fixed Equipment	39,074,338	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)	102,819,662	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	102,819,662	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part II | Date/Time Prepared: 5/25/2017 9:36 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	3,383,556	0	522,236	369,198	0	1.00
1.01	MOB	226,553	0	0	0	0	1.01
1.02	OPS	147,326	0	0	0	0	1.02
3.00	Total (sum of lines 1-2)	3,757,435	0	522,236	369,198	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	4,274,990	1.00
1.01	MOB	0	226,553	1.01
1.02	OPS	0	147,326	1.02
3.00	Total (sum of lines 1-2)	0	4,648,869	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 5/25/2017 9:36 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	4,274,990	0	4,274,990	0.919576	0	1.00
1.01	MOB	226,553	0	226,553	0.048733	0	1.01
1.02	OPS	147,326	0	147,326	0.031691	0	1.02
3.00	Total (sum of lines 1-2)	4,648,869	0	4,648,869	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	3,355,803	0	1.00
1.01	MOB	0	0	0	226,553	0	1.01
1.02	OPS	0	0	0	147,326	0	1.02
3.00	Total (sum of lines 1-2)	0	0	0	3,729,682	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	522,236	117,867	0	0	3,995,906	1.00
1.01	MOB	0	0	0	0	226,553	1.01
1.02	OPS	0	0	0	0	147,326	1.02
3.00	Total (sum of lines 1-2)	522,236	117,867	0	0	4,369,785	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/25/2017 9:36 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - MOB (chapter 2)		0	MOB	1.01	0	1.01
1.02	Investment income - OPS (chapter 2)		0	OPS	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,404,572			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	A	-341,739	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - MOB		0	MOB	1.01	0	26.01
26.02	Depreciation - OPS		0	OPS	1.02	0	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/25/2017 9:36 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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER REVENUE - VENDING COMMISSIO	B	-7,136	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	OTHER REVENUE - CASH OVER/SHORT	B	-166	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	OTHER REVENUE - MISCELLAN	B	-3,980	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	OTHER REVENUE - BAD DEBT	B	-190	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	OTHER REVENUE - MEDICARE	B	114	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	OTHER REVENUE - BLUE CROS	B	-243	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	OTHER REVENUE - MEDICAID	B	-186	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	OTHER REVENUE - SCRAP SAL	B	-6,848	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	OTHER REVENUE - CASH OVER	B	62	ADMINISTRATIVE & GENERAL	5.00	0	41.00
44.00	MHL A/P DISCOUNTS	B	88	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	MHL TELEPHONE SERVICE	B	-9,945	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	MEALS ON WHEELS	B	-24,377	DIETARY	10.00	0	45.01
45.02	OTHER REVENEU - NUTRITIONALS	B	-523	DIETARY	10.00	0	45.02
45.03	OTHER REVENUE - REBATES	B	-519	DIETARY	10.00	0	45.03
45.05	HIM MEDICAL RECORDS FEES	B	-28,005	MEDICAL RECORDS & LIBRARY	16.00	0	45.05
45.06	OTHER REVENUE - CPR TRAINING	B	-964	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.06
45.08	OTHER REVENUE - ACLS REVENUE	B	-30	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.08
45.09	INTEREST INCOME	B	-2,813	NEW CAP REL COSTS-BLDG & FIXT	1.00	12	45.09
45.10	PATIENT TELEVISIONS	A	-664	OPERATION OF PLANT	7.00	0	45.10
45.11	PATIENT TELEVISIONS	A	-1,006	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.11
45.12	PATIENT TELEPHONES	A	-2,802	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.12
45.13	PATIENT TELEPHONES	A	-3,284	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.13
45.14	PATIENT TELEPHONES	A	-1,777	ADMINISTRATIVE & GENERAL	5.00	0	45.14
45.15	IHA & AHA LOBBYING FEES	A	-5,988	ADMINISTRATIVE & GENERAL	5.00	0	45.15
45.16	GIFT SHOP	A	-13,489	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.16
45.17	GIFT SHOP	A	-8,402	OPERATION OF PLANT	7.00	0	45.17
45.18	ADVERTISING	A	-499,762	ADMINISTRATIVE & GENERAL	5.00	0	45.18
45.19	TAXES	A	-63,619	ADMINISTRATIVE & GENERAL	5.00	0	45.19
45.20	DONATION EXPENSE	A	-15,265	ADMINISTRATIVE & GENERAL	5.00	0	45.20
45.21	PHYSICIAN RECRUITMENT	A	-407,415	ADMINISTRATIVE & GENERAL	5.00	0	45.21
45.22	CAPITALIZED INTEREST	A	-6,091	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.22
45.23	VENDING	A	-2,419	OPERATION OF PLANT	7.00	0	45.23
45.24	VENDING	A	-3,883	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.24
45.25	HOSPITAL ASSESSMENT FEES	A	-1,089,762	ADMINISTRATIVE & GENERAL	5.00	0	45.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,957,600				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 5/25/2017 9:36 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	53.00	ANESTHESIOLOGY	699,585	699,585	0	239,400	0	1.00
2.00	90.00	CLINIC	4,779,991	4,674,784	105,207	179,000	865	2.00
3.00	91.00	EMERGENCY	1,001,952	1,001,952	0	246,400	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			6,481,528	6,376,321	105,207		865	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	53.00	ANESTHESIOLOGY	0	0	0	0	0	1.00
2.00	90.00	CLINIC	74,440	3,722	63,728	1,403	50,567	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			74,440	3,722	63,728	1,403	50,567	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	53.00	ANESTHESIOLOGY	0	0	0	699,585		1.00
2.00	90.00	CLINIC	1,113	76,956	28,251	4,703,035		2.00
3.00	91.00	EMERGENCY	0	0	0	1,001,952		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			1,113	76,956	28,251	6,404,572		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/25/2017 9:36 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
				NEW BLDG & FIXT	MOB	OPS		
			0	1.00	1.01	1.02	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	3,995,906	3,995,906				1.00
1.01	00101	MOB	226,553	0	226,553			1.01
1.02	00102	OPS	147,326	0	0	147,326		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,694,877	0	0	20,239	9,715,116	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,609,813	323,927	29,371	0	1,142,670	5.00
7.00	00700	OPERATION OF PLANT	2,456,208	715,222	1,365	13,375	171,923	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	225,979	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	777,367	28,060	729	493	182,342	9.00
10.00	01000	DIETARY	237,522	115,113	0	0	61,134	10.00
11.00	01100	CAFETERIA	484,861	57,406	0	0	192,185	11.00
13.00	01300	NURSING ADMINISTRATION	510,644	44,531	0	0	156,070	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,503,105	82,895	0	0	62,524	14.00
15.00	01500	PHARMACY	2,245,937	37,219	0	0	138,737	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	733,211	149,540	0	0	187,734	16.00
17.00	01700	SOCIAL SERVICE	368,506	24,947	0	0	102,418	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,193,148	593,360	0	0	622,878	30.00
31.00	03100	INTENSIVE CARE UNIT	615,140	106,114	0	0	177,233	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	288,567	18,118	0	0	75,487	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,278,736	403,949	0	0	508,808	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	694,642	99,406	0	0	181,713	52.00
53.00	05300	ANESTHESIOLOGY	41,473	35,412	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,949,602	181,336	0	9,495	341,820	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,647,994	97,156	6,903	4,428	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	173,817	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	650,339	6,910	0	0	169,556	65.00
66.00	06600	PHYSICAL THERAPY	806,840	76,728	0	0	14,265	66.00
69.00	06900	ELECTROCARDIOLOGY	392,140	9,621	14,524	0	87,948	69.00
69.01	06901	CARDIAC REHAB	137,873	111,738	0	0	37,472	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	976,870	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	506,965	14,723	22,489	0	63,307	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,071,913	7,874	87,010	0	2,239,434	90.00
91.00	09100	EMERGENCY	1,757,612	307,737	0	0	480,675	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)	50,401,486	3,649,042	162,391	48,030	7,398,333	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	6,471	0	0	0	0	194.00
194.01	07951	MOB	-2,997	0	45,820	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	837,025	45,896	0	0	171,326	194.04
194.05	07955	PHYSICIANS OFFICE	9,809,224	90,467	18,342	38,353	2,092,865	194.05
194.06	07956	THE ARBORS	0	210,501	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	179,125	0	0	0	52,141	194.07
194.08	07958	OPS	0	0	0	60,943	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	20,388	0	0	0	451	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	61,250,722	3,995,906	226,553	147,326	9,715,116	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/25/2017 9:36 am

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,105,781	8,105,781				5.00
7.00	00700	OPERATION OF PLANT	3,358,093	512,183	3,870,276			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	225,979	34,467	11,509	271,955		8.00
9.00	00900	HOUSEKEEPING	988,991	150,843	35,347	0	1,175,181	9.00
10.00	01000	DIETARY	413,769	63,109	123,004	0	0	10.00
11.00	01100	CAFETERIA	734,452	112,020	89,596	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	711,245	108,481	67,357	0	4,041	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,648,524	251,436	127,420	0	58,193	14.00
15.00	01500	PHARMACY	2,421,893	369,392	38,704	0	8,082	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,070,485	163,273	29,352	0	4,849	16.00
17.00	01700	SOCIAL SERVICE	495,871	75,631	9,431	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,409,386	520,006	604,309	64,884	398,868	30.00
31.00	03100	INTENSIVE CARE UNIT	898,487	137,039	82,542	6,014	64,659	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	382,172	58,290	7,913	14,911	2,223	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,191,493	486,773	285,112	109,791	129,318	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	975,761	148,825	70,673	0	12,730	52.00
53.00	05300	ANESTHESIOLOGY	76,885	11,727	33,369	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,482,253	378,598	237,656	12,815	64,659	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,756,481	420,424	119,767	0	28,288	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	173,817	26,511	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	826,805	126,106	61,442	0	12,124	65.00
66.00	06600	PHYSICAL THERAPY	897,833	136,939	48,315	2,331	0	66.00
69.00	06900	ELECTROCARDIOLOGY	504,233	76,907	27,534	0	24,247	69.00
69.01	06901	CARDIAC REHAB	287,083	43,786	20,381	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	976,870	148,994	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	607,484	92,655	103,982	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,406,231	977,091	249,026	0	54,960	90.00
91.00	09100	EMERGENCY	2,546,024	388,325	216,256	61,209	105,071	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)	47,574,381	6,019,831	2,699,997	271,955	972,312	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	6,471	987	1,439	0	12,932	194.00
194.01	07951	MOB	42,823	6,531	476,192	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	1,054,247	160,796	0	0	16,165	194.04
194.05	07955	PHYSICIANS OFFICE	12,049,251	1,837,784	89,915	0	88,906	194.05
194.06	07956	THE ARBORS	210,501	32,106	188,103	0	52,536	194.06
194.07	07957	PAIN MANAGEMENT	231,266	35,273	0	0	0	194.07
194.08	07958	OPS	60,943	9,295	414,630	0	32,330	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	20,839	3,178	0	0	0	194.09
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	61,250,722	8,105,781	3,870,276	271,955	1,175,181	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/25/2017 9:36 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	599,882					10.00
11.00	01100	CAFETERIA	0	936,068				11.00
13.00	01300	NURSING ADMINISTRATION	0	16,456	907,580			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,887	0	2,102,460		14.00
15.00	01500	PHARMACY	0	29,023	0	0	2,867,094	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	15,707	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	343,252	114,464	296,761	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	31,800	29,829	77,336	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	12,342	31,997	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	0	81,800	212,075	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	29,711	77,028	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	57,519	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	31,033	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,617	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	21,836	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	6,514	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,102,460	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,867,094	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	8,495	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	252,180	0	0	0	90.00
91.00	09100	EMERGENCY	0	81,919	212,383	0	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)	375,052	809,332	907,580	2,102,460	2,867,094	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	28,341	0	0	0	194.04
194.05	07955	PHYSICIANS OFFICE	0	98,395	0	0	0	194.05
194.06	07956	THE ARBORS	224,830	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0	194.07
194.08	07958	OPS	0	0	0	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	0	0	0	194.09
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)	599,882	936,068	907,580	2,102,460	2,867,094	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/25/2017 9:36 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,267,959					16.00
17.00	01700	SOCIAL SERVICE	0	596,640				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	99,360	470,735	6,322,025	0	6,322,025	30.00
31.00	03100	INTENSIVE CARE UNIT	9,873	47,757	1,385,336	0	1,385,336	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	12,954	19,971	542,773	0	542,773	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	265,589	4,631	4,766,582	0	4,766,582	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	31,182	0	1,345,910	0	1,345,910	52.00
53.00	05300	ANESTHESIOLOGY	13,349	0	135,330	0	135,330	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	119,625	0	3,353,125	0	3,353,125	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	167,257	0	3,492,217	0	3,492,217	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	11,775	0	212,103	0	212,103	63.00
65.00	06500	RESPIRATORY THERAPY	52,550	0	1,110,060	0	1,110,060	65.00
66.00	06600	PHYSICAL THERAPY	33,112	0	1,122,147	0	1,122,147	66.00
69.00	06900	ELECTROCARDIOLOGY	33,507	0	688,264	0	688,264	69.00
69.01	06901	CARDIAC REHAB	3,851	0	361,615	0	361,615	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,102,460	0	2,102,460	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	1,125,864	0	1,125,864	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,867,094	0	2,867,094	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	93,997	0	906,613	0	906,613	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	4,342	7,943,830	0	7,943,830	90.00
91.00	09100	EMERGENCY	118,491	49,204	3,778,882	0	3,778,882	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)	1,066,472	596,640	43,562,230	0	43,562,230	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	21,829	0	21,829	194.00
194.01	07951	MOB	0	0	525,546	0	525,546	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	0	1,259,549	0	1,259,549	194.04
194.05	07955	PHYSICIANS OFFICE	201,487	0	14,365,738	0	14,365,738	194.05
194.06	07956	THE ARBORS	0	0	708,076	0	708,076	194.06
194.07	07957	PAIN MANAGEMENT	0	0	266,539	0	266,539	194.07
194.08	07958	OPS	0	0	517,198	0	517,198	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	24,017	0	24,017	194.09
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,267,959	596,640	61,250,722	0	61,250,722	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/25/2017 9:36 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS MOB	CAPITAL RELATED COSTS OPS	Subtotal	
			0	1.00	1.01	1.02	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	20,239	20,239	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	323,927	29,371	0	353,298	5.00
7.00	00700	OPERATION OF PLANT	0	715,222	1,365	13,375	729,962	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	28,060	729	493	29,282	9.00
10.00	01000	DIETARY	0	115,113	0	0	115,113	10.00
11.00	01100	CAFETERIA	0	57,406	0	0	57,406	11.00
13.00	01300	NURSING ADMINISTRATION	0	44,531	0	0	44,531	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	82,895	0	0	82,895	14.00
15.00	01500	PHARMACY	0	37,219	0	0	37,219	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	149,540	0	0	149,540	16.00
17.00	01700	SOCIAL SERVICE	0	24,947	0	0	24,947	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	593,360	0	0	593,360	30.00
31.00	03100	INTENSIVE CARE UNIT	0	106,114	0	0	106,114	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	18,118	0	0	18,118	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	403,949	0	0	403,949	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	99,406	0	0	99,406	52.00
53.00	05300	ANESTHESIOLOGY	0	35,412	0	0	35,412	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	181,336	0	9,495	190,831	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	97,156	6,903	4,428	108,487	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	6,910	0	0	6,910	65.00
66.00	06600	PHYSICAL THERAPY	0	76,728	0	0	76,728	66.00
69.00	06900	ELECTROCARDIOLOGY	0	9,621	14,524	0	24,145	69.00
69.01	06901	CARDIAC REHAB	0	111,738	0	0	111,738	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	14,723	22,489	0	37,212	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	7,874	87,010	0	94,884	90.00
91.00	09100	EMERGENCY	0	307,737	0	0	307,737	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	3,649,042	162,391	48,030	3,859,463	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	45,820	0	45,820	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	45,896	0	0	45,896	194.04
194.05	07955	PHYSICIANS OFFICE	0	90,467	18,342	38,353	147,162	194.05
194.06	07956	THE ARBORS	0	210,501	0	0	210,501	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0	194.07
194.08	07958	OPS	0	0	0	60,943	60,943	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	0	0	0	194.09
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	3,995,906	226,553	147,326	4,369,785	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/25/2017 9:36 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	20,239					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,379	355,677				5.00
7.00	00700	OPERATION OF PLANT	358	22,476	752,796			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,512	2,239	3,751		8.00
9.00	00900	HOUSEKEEPING	380	6,619	6,875	0	43,156	9.00
10.00	01000	DIETARY	127	2,769	23,925	0	0	10.00
11.00	01100	CAFETERIA	400	4,916	17,427	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	325	4,760	13,101	0	148	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	130	11,034	24,784	0	2,137	14.00
15.00	01500	PHARMACY	289	16,210	7,528	0	297	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	391	7,165	5,709	0	178	16.00
17.00	01700	SOCIAL SERVICE	213	3,319	1,834	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,297	22,819	117,545	895	14,649	30.00
31.00	03100	INTENSIVE CARE UNIT	369	6,014	16,055	83	2,374	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	157	2,558	1,539	206	82	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,059	21,361	55,456	1,514	4,749	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	378	6,531	13,746	0	467	52.00
53.00	05300	ANESTHESIOLOGY	0	515	6,490	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	712	16,614	46,226	177	2,374	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	18,449	23,296	0	1,039	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,163	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	353	5,534	11,951	0	445	65.00
66.00	06600	PHYSICAL THERAPY	30	6,009	9,398	32	0	66.00
69.00	06900	ELECTROCARDIOLOGY	183	3,375	5,356	0	890	69.00
69.01	06901	CARDIAC REHAB	78	1,921	3,964	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	6,538	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	132	4,066	20,225	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,674	42,877	48,437	0	2,018	90.00
91.00	09100	EMERGENCY	1,001	17,041	42,063	844	3,859	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)	15,415	264,165	525,169	3,751	35,706	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	43	280	0	475	194.00
194.01	07951	MOB	0	287	92,623	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	357	7,056	0	0	594	194.04
194.05	07955	PHYSICIANS OFFICE	4,357	80,622	17,489	0	3,265	194.05
194.06	07956	THE ARBORS	0	1,409	36,587	0	1,929	194.06
194.07	07957	PAIN MANAGEMENT	109	1,548	0	0	0	194.07
194.08	07958	OPS	0	408	80,648	0	1,187	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	1	139	0	0	0	194.09
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)	20,239	355,677	752,796	3,751	43,156	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/25/2017 9:36 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	141,934					10.00
11.00	01100	CAFETERIA	0	80,149				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,409	64,274			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,446	0	122,426		14.00
15.00	01500	PHARMACY	0	2,485	0	0	64,028	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,345	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	81,215	9,801	21,016	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	7,524	2,554	5,477	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	1,057	2,266	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	0	7,004	15,019	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,544	5,455	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,925	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,657	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	310	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,870	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	558	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	122,426	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	64,028	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	727	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	21,591	0	0	0	90.00
91.00	09100	EMERGENCY	0	7,014	15,041	0	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)	88,739	69,297	64,274	122,426	64,028	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	2,427	0	0	0	194.04
194.05	07955	PHYSICIANS OFFICE	0	8,425	0	0	0	194.05
194.06	07956	THE ARBORS	53,195	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0	194.07
194.08	07958	OPS	0	0	0	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	0	0	0	194.09
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)	141,934	80,149	64,274	122,426	64,028	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/25/2017 9:36 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
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	162,983					16.00
17.00	01700	SOCIAL SERVICE	0	31,658				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,774	24,977	900,348	0	900,348	30.00
31.00	03100	INTENSIVE CARE UNIT	1,269	2,534	150,367	0	150,367	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	1,665	1,060	28,708	0	28,708	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	34,114	246	544,471	0	544,471	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,009	0	132,536	0	132,536	52.00
53.00	05300	ANESTHESIOLOGY	1,716	0	44,133	0	44,133	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,380	0	277,239	0	277,239	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	21,503	0	172,774	0	172,774	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,514	0	2,677	0	2,677	63.00
65.00	06500	RESPIRATORY THERAPY	6,756	0	34,606	0	34,606	65.00
66.00	06600	PHYSICAL THERAPY	4,257	0	96,764	0	96,764	66.00
69.00	06900	ELECTROCARDIOLOGY	4,308	0	40,127	0	40,127	69.00
69.01	06901	CARDIAC REHAB	495	0	118,754	0	118,754	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	122,426	0	122,426	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	6,538	0	6,538	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	64,028	0	64,028	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	12,085	0	74,447	0	74,447	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	230	214,711	0	214,711	90.00
91.00	09100	EMERGENCY	15,234	2,611	412,445	0	412,445	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)	137,079	31,658	3,438,099	0	3,438,099	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	798	0	798	194.00
194.01	07951	MOB	0	0	138,730	0	138,730	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	0	0	56,330	0	56,330	194.04
194.05	07955	PHYSICIANS OFFICE	25,904	0	287,224	0	287,224	194.05
194.06	07956	THE ARBORS	0	0	303,621	0	303,621	194.06
194.07	07957	PAIN MANAGEMENT	0	0	1,657	0	1,657	194.07
194.08	07958	OPS	0	0	143,186	0	143,186	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	140	0	140	194.09
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	162,983	31,658	4,369,785	0	4,369,785	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/25/2017 9:36 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	OPS (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	1.02	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	198,940					1.00
1.01	00101	MOB	0	44,144				1.01
1.02	00102	OPS	0	0	24,189			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	3,323	31,018,709		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,127	5,723	0	3,648,348	-8,105,781	5.00
7.00	00700	OPERATION OF PLANT	35,608	266	2,196	548,920	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,397	142	81	582,188	0	9.00
10.00	01000	DIETARY	5,731	0	0	195,190	0	10.00
11.00	01100	CAFETERIA	2,858	0	0	613,614	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,217	0	0	498,306	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,127	0	0	199,627	0	14.00
15.00	01500	PHARMACY	1,853	0	0	442,962	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,445	0	0	599,401	0	16.00
17.00	01700	SOCIAL SERVICE	1,242	0	0	327,002	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,541	0	0	1,988,743	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,283	0	0	565,873	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	902	0	0	241,016	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	20,111	0	0	1,624,537	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,949	0	0	580,177	0	52.00
53.00	05300	ANESTHESIOLOGY	1,763	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,028	0	1,559	1,091,372	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,837	1,345	727	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	344	0	0	541,364	0	65.00
66.00	06600	PHYSICAL THERAPY	3,820	0	0	45,545	0	66.00
69.00	06900	ELECTROCARDIOLOGY	479	2,830	0	280,804	0	69.00
69.01	06901	CARDIAC REHAB	5,563	0	0	119,643	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	733	4,382	0	202,128	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	392	16,954	0	7,150,153	0	90.00
91.00	09100	EMERGENCY	15,321	0	0	1,534,711	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)	181,671	31,642	7,886	23,621,624	-8,105,781	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	MOB	0	8,928	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	2,285	0	0	547,014	0	194.04
194.05	07955	PHYSICIANS OFFICE	4,504	3,574	6,297	6,682,156	0	194.05
194.06	07956	THE ARBORS	10,480	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	166,476	0	194.07
194.08	07958	OPS	0	0	10,006	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	0	1,439	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,995,906	226,553	147,326	9,715,116		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.085986	5.132136	6.090620	0.313202		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				20,239		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/25/2017 9:36 am

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	OPS (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		1.00	1.01	1.02	4.00	5A	
205.00	Unit cost multiplier (Wkst. B, Part II)				0.000652		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/25/2017 9:36 am

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	53,144,941					5.00
7.00	00700	OPERATION OF PLANT	3,358,093	193,696				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	225,979	576	318,220			8.00
9.00	00900	HOUSEKEEPING	988,991	1,769	0	5,816		9.00
10.00	01000	DIETARY	413,769	6,156	0	0	8,338	10.00
11.00	01100	CAFETERIA	734,452	4,484	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	711,245	3,371	0	20	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,648,524	6,377	0	288	0	14.00
15.00	01500	PHARMACY	2,421,893	1,937	0	40	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,070,485	1,469	0	24	0	16.00
17.00	01700	SOCIAL SERVICE	495,871	472	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,409,386	30,244	75,922	1,974	4,771	30.00
31.00	03100	INTENSIVE CARE UNIT	898,487	4,131	7,037	320	442	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	382,172	396	17,448	11	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	3,191,493	14,269	128,468	640	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	975,761	3,537	0	63	0	52.00
53.00	05300	ANESTHESIOLOGY	76,885	1,670	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,482,253	11,894	14,995	320	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,756,481	5,994	0	140	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	173,817	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	826,805	3,075	0	60	0	65.00
66.00	06600	PHYSICAL THERAPY	897,833	2,418	2,728	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	504,233	1,378	0	120	0	69.00
69.01	06901	CARDIAC REHAB	287,083	1,020	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	976,870	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	607,484	5,204	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,406,231	12,463	0	272	0	90.00
91.00	09100	EMERGENCY	2,546,024	10,823	71,622	520	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)	39,468,600	135,127	318,220	4,812	5,213	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	6,471	72	0	64	0	194.00
194.01	07951	MOB	42,823	23,832	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	1,054,247	0	0	80	0	194.04
194.05	07955	PHYSICIANS OFFICE	12,049,251	4,500	0	440	0	194.05
194.06	07956	THE ARBORS	210,501	9,414	0	260	3,125	194.06
194.07	07957	PAIN MANAGEMENT	231,266	0	0	0	0	194.07
194.08	07958	OPS	60,943	20,751	0	160	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	20,839	0	0	0	0	194.09
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)	8,105,781	3,870,276	271,955	1,175,181	599,882	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.152522	19.981187	0.854613	202.060007	71.945550	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	355,677	752,796	3,751	43,156	141,934	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006693	3.886482	0.011787	7.420220	17.022547	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/25/2017 9:36 am

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS)	MEDICAL RECORDS & LIBRARY (REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	OPS						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	677,542					11.00
13.00	01300	NURSING ADMINISTRATION	11,911	253,382				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,223	0	100			14.00
15.00	01500	PHARMACY	21,007	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	132,965,281	16.00
17.00	01700	SOCIAL SERVICE	11,369	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	82,851	82,851	0	0	10,419,440	30.00
31.00	03100	INTENSIVE CARE UNIT	21,591	21,591	0	0	1,035,377	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	8,933	8,933	0	0	1,358,401	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	59,208	59,208	0	0	27,851,023	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,505	21,505	0	0	3,269,956	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,399,819	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,633	0	0	0	12,544,567	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	17,539,536	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	1,234,758	63.00
65.00	06500	RESPIRATORY THERAPY	22,462	0	0	0	5,510,696	65.00
66.00	06600	PHYSICAL THERAPY	2,618	0	0	0	3,472,345	66.00
69.00	06900	ELECTROCARDIOLOGY	15,805	0	0	0	3,513,706	69.00
69.01	06901	CARDIAC REHAB	4,715	0	0	0	403,880	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	100	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	6,149	0	0	0	9,857,077	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	182,534	0	0	0	0	90.00
91.00	09100	EMERGENCY	59,294	59,294	0	0	12,425,651	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)	585,808	253,382	100	100	111,836,232	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	NONREIMBURSABLE OTHER	0	0	0	0	0	194.02
194.03	07953	PIH	0	0	0	0	0	194.03
194.04	07954	HEALTH COMPANIES	20,514	0	0	0	0	194.04
194.05	07955	PHYSICIANS OFFICE	71,220	0	0	0	21,129,049	194.05
194.06	07956	THE ARBORS	0	0	0	0	0	194.06
194.07	07957	PAIN MANAGEMENT	0	0	0	0	0	194.07
194.08	07958	OPS	0	0	0	0	0	194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0	0	0	0	0	194.09
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)	936,068	907,580	2,102,460	2,867,094	1,267,959	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.381565	3.581865	21,024.600000	28,670.940000	0.009536	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	80,149	64,274	122,426	64,028	162,983	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.118294	0.253664	1,224.260000	640.280000	0.001226	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/25/2017 9:36 am

		Cost Center Description	SOCIAL SERVICE (HOURS)		
			17.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	MOB			1.01
1.02	00102	OPS			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
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	20,614		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	16,264		30.00
31.00	03100	INTENSIVE CARE UNIT	1,650		31.00
41.00	04100	SUBPROVIDER - IRF	0		41.00
42.00	04200	SUBPROVIDER	0		42.00
43.00	04300	NURSERY	690		43.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	160		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0		59.00
60.00	06000	LABORATORY	0		60.00
60.01	06001	BLOOD LABORATORY	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		63.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
69.01	06901	CARDIAC REHAB	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	150		90.00
91.00	09100	EMERGENCY	1,700		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,614		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	FOUNDATION	0		194.00
194.01	07951	MOB	0		194.01
194.02	07952	NONREIMBURSABLE OTHER	0		194.02
194.03	07953	PIH	0		194.03
194.04	07954	HEALTH COMPANIES	0		194.04
194.05	07955	PHYSICIANS OFFICE	0		194.05
194.06	07956	THE ARBORS	0		194.06
194.07	07957	PAIN MANAGEMENT	0		194.07
194.08	07958	OPS	0		194.08
194.09	07959	MHL ROCHESTER HEALTH CENTER	0		194.09
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)	596,640		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.943436		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	31,658		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.535752		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/25/2017 9:36 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,322,025		6,322,025	0	6,322,025	30.00
31.00	03100	INTENSIVE CARE UNIT	1,385,336		1,385,336	0	1,385,336	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	542,773		542,773	0	542,773	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,766,582		4,766,582	0	4,766,582	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,345,910		1,345,910	0	1,345,910	52.00
53.00	05300	ANESTHESIOLOGY	135,330		135,330	0	135,330	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,353,125		3,353,125	0	3,353,125	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	3,492,217		3,492,217	0	3,492,217	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	212,103		212,103	0	212,103	63.00
65.00	06500	RESPIRATORY THERAPY	1,110,060	0	1,110,060	0	1,110,060	65.00
66.00	06600	PHYSICAL THERAPY	1,122,147	0	1,122,147	0	1,122,147	66.00
69.00	06900	ELECTROCARDIOLOGY	688,264		688,264	0	688,264	69.00
69.01	06901	CARDIAC REHAB	361,615		361,615	0	361,615	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,102,460		2,102,460	0	2,102,460	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,125,864		1,125,864	0	1,125,864	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,867,094		2,867,094	0	2,867,094	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	906,613		906,613	0	906,613	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,943,830		7,943,830	28,251	7,972,081	90.00
91.00	09100	EMERGENCY	3,778,882		3,778,882	0	3,778,882	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,377,827		1,377,827		1,377,827	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	44,940,057	0	44,940,057	28,251	44,968,308	200.00
201.00		Less Observation Beds	1,377,827		1,377,827		1,377,827	201.00
202.00		Total (see instructions)	43,562,230	0	43,562,230	28,251	43,590,481	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/25/2017 9:36 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,947,775		7,947,775			30.00
31.00	03100	INTENSIVE CARE UNIT	927,912		927,912			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	1,356,337		1,356,337			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,134,362	23,716,661	27,851,023	0.171146	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,267,895	473,390	2,741,285	0.490978	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	231,520	1,168,299	1,399,819	0.096677	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	875,964	11,668,603	12,544,567	0.267297	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	2,566,360	14,973,176	17,539,536	0.199105	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	532,007	702,751	1,234,758	0.171777	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	1,796,311	2,716,895	4,513,206	0.245958	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	370,176	3,102,169	3,472,345	0.323167	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	585,657	3,925,539	4,511,196	0.152568	0.000000	69.00
69.01	06901	CARDIAC REHAB	155	403,725	403,880	0.895353	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,531,016	5,867,231	7,398,247	0.284184	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,765,772	3,431,178	5,196,950	0.216639	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,306,544	5,034,075	9,340,619	0.306949	0.000000	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	899,967	8,957,110	9,857,077	0.091976	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	19,178	7,942,185	7,961,363	0.997798	0.000000	90.00
91.00	09100	EMERGENCY	1,353,923	11,071,728	12,425,651	0.304119	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	188,973	2,920,892	3,109,865	0.443050	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)	33,657,804	108,075,607	141,733,411			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	33,657,804	108,075,607	141,733,411			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/25/2017 9:36 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
42.00	04200	SUBPROVIDER		42.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.171146	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.490978	52.00
53.00	05300	ANESTHESIOLOGY	0.096677	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.267297	54.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.199105	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.171777	63.00
65.00	06500	RESPIRATORY THERAPY	0.245958	65.00
66.00	06600	PHYSICAL THERAPY	0.323167	66.00
69.00	06900	ELECTROCARDIOLOGY	0.152568	69.00
69.01	06901	CARDIAC REHAB	0.895353	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.284184	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.216639	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.306949	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0.091976	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	1.001346	90.00
91.00	09100	EMERGENCY	0.304119	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.443050	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: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/25/2017 9:36 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,322,025		6,322,025	0	6,322,025	30.00
31.00	03100	INTENSIVE CARE UNIT	1,385,336		1,385,336	0	1,385,336	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	542,773		542,773	0	542,773	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,766,582		4,766,582	0	4,766,582	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,345,910		1,345,910	0	1,345,910	52.00
53.00	05300	ANESTHESIOLOGY	135,330		135,330	0	135,330	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,353,125		3,353,125	0	3,353,125	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	3,492,217		3,492,217	0	3,492,217	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	212,103		212,103	0	212,103	63.00
65.00	06500	RESPIRATORY THERAPY	1,110,060	0	1,110,060	0	1,110,060	65.00
66.00	06600	PHYSICAL THERAPY	1,122,147	0	1,122,147	0	1,122,147	66.00
69.00	06900	ELECTROCARDIOLOGY	688,264		688,264	0	688,264	69.00
69.01	06901	CARDIAC REHAB	361,615		361,615	0	361,615	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,102,460		2,102,460	0	2,102,460	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,125,864		1,125,864	0	1,125,864	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,867,094		2,867,094	0	2,867,094	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	906,613		906,613	0	906,613	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,943,830		7,943,830	28,251	7,972,081	90.00
91.00	09100	EMERGENCY	3,778,882		3,778,882	0	3,778,882	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,377,827		1,377,827		1,377,827	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	44,940,057	0	44,940,057	28,251	44,968,308	200.00
201.00		Less Observation Beds	1,377,827		1,377,827		1,377,827	201.00
202.00		Total (see instructions)	43,562,230	0	43,562,230	28,251	43,590,481	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/25/2017 9:36 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,947,775		7,947,775			30.00
31.00	03100	INTENSIVE CARE UNIT	927,912		927,912			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	1,356,337		1,356,337			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,134,362	23,716,661	27,851,023	0.171146	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,267,895	473,390	2,741,285	0.490978	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	231,520	1,168,299	1,399,819	0.096677	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	875,964	11,668,603	12,544,567	0.267297	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	2,566,360	14,973,176	17,539,536	0.199105	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	532,007	702,751	1,234,758	0.171777	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	1,796,311	2,716,895	4,513,206	0.245958	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	370,176	3,102,169	3,472,345	0.323167	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	585,657	3,925,539	4,511,196	0.152568	0.000000	69.00
69.01	06901	CARDIAC REHAB	155	403,725	403,880	0.895353	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,531,016	5,867,231	7,398,247	0.284184	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,765,772	3,431,178	5,196,950	0.216639	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,306,544	5,034,075	9,340,619	0.306949	0.000000	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	899,967	8,957,110	9,857,077	0.091976	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	19,178	7,942,185	7,961,363	0.997798	0.000000	90.00
91.00	09100	EMERGENCY	1,353,923	11,071,728	12,425,651	0.304119	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	188,973	2,920,892	3,109,865	0.443050	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)	33,657,804	108,075,607	141,733,411			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	33,657,804	108,075,607	141,733,411			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/25/2017 9:36 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
42.00	04200	SUBPROVIDER		42.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	06901	CARDIAC REHAB	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part I Date/Time Prepared: 5/25/2017 9:36 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	900,348	0	900,348	6,098	147.65	30.00
31.00	INTENSIVE CARE UNIT	150,367		150,367	442	340.20	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	28,708		28,708	1,096	26.19	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	1,079,423		1,079,423	7,636		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	2,094	309,179	30.00
31.00	INTENSIVE CARE UNIT	229	77,906	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30-199)	2,323	387,085	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/25/2017 9:36 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	544,471	27,851,023	0.019549	1,195,113	23,363	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	132,536	2,741,285	0.048348	12,434	601	52.00
53.00	05300	ANESTHESIOLOGY	44,133	1,399,819	0.031528	54,866	1,730	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	277,239	12,544,567	0.022100	536,357	11,853	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	172,774	17,539,536	0.009851	1,341,223	13,212	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,677	1,234,758	0.002168	243,898	529	63.00
65.00	06500	RESPIRATORY THERAPY	34,606	4,513,206	0.007668	1,217,353	9,335	65.00
66.00	06600	PHYSICAL THERAPY	96,764	3,472,345	0.027867	251,432	7,007	66.00
69.00	06900	ELECTROCARDIOLOGY	40,127	4,511,196	0.008895	261,568	2,327	69.00
69.01	06901	CARDIAC REHAB	118,754	403,880	0.294033	155	46	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	122,426	7,398,247	0.016548	564,236	9,337	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,538	5,196,950	0.001258	1,089,695	1,371	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,028	9,340,619	0.006855	2,607,564	17,875	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	74,447	9,857,077	0.007553	491,242	3,710	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	214,711	7,961,363	0.026969	18,680	504	90.00
91.00	09100	EMERGENCY	412,445	12,425,651	0.033193	778,845	25,852	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	196,222	3,109,865	0.063097	68,044	4,293	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	2,554,898	131,501,387		10,732,705	132,945	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 5/25/2017 9:36 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
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
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	6,098	0.00	2,094	0		30.00
31.00	03100	INTENSIVE CARE UNIT	442	0.00	229	0		31.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0		41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0		42.00
43.00	04300	NURSERY	1,096	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)	7,636		2,323	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/25/2017 9:36 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
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
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		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: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/25/2017 9:36 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	27,851,023	0.000000	0.000000	1,195,113	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,741,285	0.000000	0.000000	12,434	52.00
53.00	05300	ANESTHESIOLOGY	0	1,399,819	0.000000	0.000000	54,866	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,544,567	0.000000	0.000000	536,357	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	17,539,536	0.000000	0.000000	1,341,223	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,234,758	0.000000	0.000000	243,898	63.00
65.00	06500	RESPIRATORY THERAPY	0	4,513,206	0.000000	0.000000	1,217,353	65.00
66.00	06600	PHYSICAL THERAPY	0	3,472,345	0.000000	0.000000	251,432	66.00
69.00	06900	ELECTROCARDIOLOGY	0	4,511,196	0.000000	0.000000	261,568	69.00
69.01	06901	CARDIAC REHAB	0	403,880	0.000000	0.000000	155	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,398,247	0.000000	0.000000	564,236	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	5,196,950	0.000000	0.000000	1,089,695	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,340,619	0.000000	0.000000	2,607,564	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	9,857,077	0.000000	0.000000	491,242	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	7,961,363	0.000000	0.000000	18,680	90.00
91.00	09100	EMERGENCY	0	12,425,651	0.000000	0.000000	778,845	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,109,865	0.000000	0.000000	68,044	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	131,501,387			10,732,705	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/25/2017 9:36 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	4,918,924	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	172,873	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,837,551	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	1,793,203	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	203,968	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	1,297,541	0		65.00
66.00	06600	PHYSICAL THERAPY	0	24,704	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,335,741	0		69.00
69.01	06901	CARDIAC REHAB	0	172,343	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,173,661	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	727,788	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,367,528	0		73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0	2,804,358	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	1,316,115	0		90.00
91.00	09100	EMERGENCY	0	2,373,827	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	893,254	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	23,413,379	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/25/2017 9:36 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	0.171146	4,918,924	0	0	841,854	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.490978	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.096677	172,873	0	0	16,713	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.267297	2,837,551	1	925	758,469	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.199105	1,793,203	0	0	357,036	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.171777	203,968	0	0	35,037	63.00
65.00	06500	RESPIRATORY THERAPY	0.245958	1,297,541	1	478	319,141	65.00
66.00	06600	PHYSICAL THERAPY	0.323167	24,704	0	0	7,984	66.00
69.00	06900	ELECTROCARDIOLOGY	0.152568	1,335,741	0	0	203,791	69.00
69.01	06901	CARDIAC REHAB	0.895353	172,343	0	0	154,308	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.284184	1,173,661	0	0	333,536	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.216639	727,788	0	0	157,667	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.306949	1,367,528	73	53,621	419,761	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0.091976	2,804,358	51	37,353	257,934	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.997798	1,316,115	127	4,692	1,313,217	90.00
91.00	09100	EMERGENCY	0.304119	2,373,827	0	0	721,926	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.443050	893,254	0	0	395,756	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		23,413,379	253	97,069	6,294,130	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		23,413,379	253	97,069	6,294,130	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/25/2017 9:36 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
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	247	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	118	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22	16,459	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	5	3,436	76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	127	4,682	90.00
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)	154	24,942	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	154	24,942	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/25/2017 9:36 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)	6,098	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,098	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)	4,769	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)	2,094	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)	6,322,025	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)	6,322,025	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)	6,322,025	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)	1,036.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,170,934	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)	2,170,934	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/25/2017 9:36 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	1,385,336	442	3,134.24	229	717,741	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)	2,616,676	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,505,351	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)	387,085	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	132,945	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	520,030	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,985,321	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,329	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,036.74	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,377,827	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/25/2017 9:36 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	900,348	6,322,025	0.142414	1,377,827	196,222	90.00
91.00	Nursing School cost	0	6,322,025	0.000000	1,377,827	0	91.00
92.00	Allied health cost	0	6,322,025	0.000000	1,377,827	0	92.00
93.00	All other Medical Education	0	6,322,025	0.000000	1,377,827	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/25/2017 9:36 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,098	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,098	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)	4,769	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)	223	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)	1,096	15.00
16.00	Nursery days (title V or XIX only)	166	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)	6,322,025	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)	6,322,025	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)	6,322,025	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)	1,036.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	231,193	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)	231,193	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/25/2017 9:36 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	542,773	1,096	495.23	166	82,208	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,385,336	442	3,134.24	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	320,663	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	634,064	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,329	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,036.74	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,377,827	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/25/2017 9:36 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	900,348	6,322,025	0.142414	1,377,827	196,222	90.00
91.00	Nursing School cost	0	6,322,025	0.000000	1,377,827	0	91.00
92.00	Allied health cost	0	6,322,025	0.000000	1,377,827	0	92.00
93.00	All other Medical Education	0	6,322,025	0.000000	1,377,827	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/25/2017 9:36 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,643,268		30.00
31.00	03100	INTENSIVE CARE UNIT		445,306		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.171146	1,195,113	204,539	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.490978	12,434	6,105	52.00
53.00	05300	ANESTHESIOLOGY	0.096677	54,866	5,304	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.267297	536,357	143,367	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.199105	1,341,223	267,044	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.171777	243,898	41,896	63.00
65.00	06500	RESPIRATORY THERAPY	0.245958	1,217,353	299,418	65.00
66.00	06600	PHYSICAL THERAPY	0.323167	251,432	81,255	66.00
69.00	06900	ELECTROCARDIOLOGY	0.152568	261,568	39,907	69.00
69.01	06901	CARDIAC REHAB	0.895353	155	139	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.284184	564,236	160,347	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.216639	1,089,695	236,070	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.306949	2,607,564	800,389	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0.091976	491,242	45,182	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.001346	18,680	18,705	90.00
91.00	09100	EMERGENCY	0.304119	778,845	236,862	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.443050	68,044	30,147	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		10,732,705	2,616,676	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)		10,732,705		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/25/2017 9:36 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		368,090		30.00
31.00	03100	INTENSIVE CARE UNIT		20,169		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		174,572		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.171146	261,931	44,828	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.490978	242,432	119,029	52.00
53.00	05300	ANESTHESIOLOGY	0.096677	17,221	1,665	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.267297	27,042	7,228	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.199105	108,001	21,504	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.171777	26,495	4,551	63.00
65.00	06500	RESPIRATORY THERAPY	0.245958	64,227	15,797	65.00
66.00	06600	PHYSICAL THERAPY	0.323167	6,136	1,983	66.00
69.00	06900	ELECTROCARDIOLOGY	0.152568	7,677	1,171	69.00
69.01	06901	CARDIAC REHAB	0.895353	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.284184	117,480	33,386	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.216639	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.306949	159,067	48,825	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0.091976	20,941	1,926	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.997798	80	80	90.00
91.00	09100	EMERGENCY	0.304119	48,318	14,694	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.443050	9,020	3,996	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,116,068	320,663	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,116,068		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0072 | Component CCN: 15-U072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/25/2017 9:36 am

Title XIX | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.171146	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.490978	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.096677	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.267297	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.199105	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.171777	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.245958	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.323167	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.152568	0	0	69.00
69.01	06901	CARDIAC REHAB	0.895353	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.284184	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.216639	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.306949	0	0	73.00
76.00	03020	NUCLEAR MEDICINE-DIAGNOSTIC	0.091976	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.997798	0	0	90.00
91.00	09100	EMERGENCY	0.304119	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.443050	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0072	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/25/2017 9:36 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,994,282	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,104,197	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)	70,532	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)	79.37	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)	3.31	30.00
31.00	Percentage of Medicaid patient days (see instructions)	27.72	31.00
32.00	Sum of lines 30 and 31	31.03	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00
34.00	Disproportionate share adjustment (see instructions)	122,955	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0072	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/25/2017 9:36 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)	0.000049380	0.000050036	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	316,335	299,091	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	236,819	75,387	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	312,206		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)	4,604,172		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	6,229,754		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	6,229,754	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	334,634	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	6,564,388	59.00
60.00	Primary payer payments	50,406	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	6,513,982	61.00
62.00	Deductibles billed to program beneficiaries	664,468	62.00
63.00	Coinsurance billed to program beneficiaries	0	63.00
64.00	Allowable bad debts (see instructions)	96,754	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	62,890	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	96,754	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	5,912,404	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)	-12,583	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0072	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/25/2017 9:36 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2016	599,313	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)	2017	238,853	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)		6,737,987	71.00
71.01	Sequestration adjustment (see instructions)		134,760	71.01
72.00	Interim payments		6,608,546	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)		-5,319	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/25/2017 9:36 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,994,282	0	2,994,282		2,994,282	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,104,197	0		1,104,197	1,104,197	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	70,532	0	70,532	0	70,532	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	122,955	0	89,829	33,126	122,955	11.00
11.01	Uncompensated care payments	36.00	312,206	0	312,206	0	312,206	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	4,604,172	0	3,466,849	1,137,323	4,604,172	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	6,229,754	0	4,500,297	1,729,457	6,229,754	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,229,754	0	4,500,297	1,729,457	6,229,754	15.00
16.00	Payment for inpatient program capital	50.00	334,634	0	246,738	87,896	334,634	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/25/2017 9:36 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	4,747,035	1,817,353	6,564,388	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	324,290	0	236,394	87,896	324,290	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	10,344	0	10,344	0	10,344	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	334,634	0	246,738	87,896	334,634	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.126250	0.131429		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			599,313		599,313	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				238,853	238,853	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/25/2017 9:36 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,994,282	2,994,282		2,994,282	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,104,197		1,104,197	1,104,197	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	70,532	70,532	0	70,532	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	122,955	89,829	33,126	122,955	11.00
11.01	Uncompensated care payments	36.00	312,206	236,819	75,387	312,206	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	4,604,172	3,391,462	1,212,710	4,604,172	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	6,229,754	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,229,754	5,017,044	1,212,710	6,229,754	15.00
16.00	Payment for inpatient program capital	50.00	334,634	246,738	87,896	334,634	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			5,263,782	1,300,606	6,564,388	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/25/2017 9:36 am

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	324,290	236,394	87,896	324,290	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	10,344	10,344	0	10,344	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	334,634	246,738	87,896	334,634	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	599,313	599,313		599,313	28.00
29.00	Low volume adjustment on or after October 1	70.97	238,853		238,853	238,853	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-12,583	570	-13,153	-12,583	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0072	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/25/2017 9:36 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	25,096	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	6,294,130	2.00
3.00	PPS payments	6,260,541	3.00
4.00	Outlier payment (see instructions)	138,307	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)	25,096	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	97,322	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)	97,322	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)	97,322	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	72,226	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)	25,096	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)	6,398,848	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	26	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,425,913	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	4,998,005	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	4,998,005	30.00
31.00	Primary payer payments	934	31.00
32.00	Subtotal (line 30 minus line 31)	4,997,071	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)	225,362	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	146,485	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	224,982	36.00
37.00	Subtotal (see instructions)	5,143,556	37.00
38.00	MSP-LCC reconciliation amount from PS&R	1,099	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)	5,142,457	40.00
40.01	Sequestration adjustment (see instructions)	102,849	40.01
41.00	Interim payments	4,900,930	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	138,678	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: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2017 9:36 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		6,608,546		4,900,930	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		6,608,546		4,900,930	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		138,678	6.01
6.02	SETTLEMENT TO PROGRAM		5,319		0	6.02
7.00	Total Medicare program liability (see instructions)		6,603,227		5,039,608	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0072 | Component CCN: 15-U072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2017 9:36 am

Title XVIII | Swing Beds - SNF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0072	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/25/2017 9:36 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	1,693	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2,323	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	147	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	5,211	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	141,733,411	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,630,892	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-0072 Component CCN: 15-U072	Period: From 01/01/2016 To 12/31/2016	Worksheet E-2 Date/Time Prepared: 5/25/2017 9:36 am
	Title XVIII	Swing Beds - SNF	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-0072 Component CCN: 15-U072	Period: From 01/01/2016 To 12/31/2016	Worksheet E-2 Date/Time Prepared: 5/25/2017 9:36 am
	Title XIX	Swing Beds - SNF	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0072	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 5/25/2017 9:36 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	634,064		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	634,064	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	634,064	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	562,830		8.00
9.00	Ancillary service charges	1,116,068	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,678,898	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,678,898	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,044,834	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	634,064	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	634,064	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	634,064	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	634,064	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	634,064	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)	634,064	0	40.00
41.00	Interim payments	846,057	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-211,993	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: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 5/25/2017 9:36 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	26,055,770	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	27,663,418	0	0	0	4.00
5.00	Other receivable	1,703,810	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-18,953,186	0	0	0	6.00
7.00	Inventory	1,521,090	0	0	0	7.00
8.00	Prepaid expenses	1,195,360	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	27,247	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	39,213,509	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	205,783	0	0	0	12.00
13.00	Land improvements	566,240	0	0	0	13.00
14.00	Accumulated depreciation	-321,231	0	0	0	14.00
15.00	Buildings	60,371,036	0	0	0	15.00
16.00	Accumulated depreciation	-34,457,330	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	7,090,757	0	0	0	19.00
20.00	Accumulated depreciation	-2,801,253	0	0	0	20.00
21.00	Automobiles and trucks	97,022	0	0	0	21.00
22.00	Accumulated depreciation	-87,014	0	0	0	22.00
23.00	Major movable equipment	34,488,821	0	0	0	23.00
24.00	Accumulated depreciation	-26,341,511	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	38,811,320	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	15,387,846	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	15,387,846	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	93,412,675	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	7,391,258	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,010,044	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,928,018	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,023,843	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,353,163	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	18,936,608	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	18,936,608	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	31,289,771	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	62,122,904				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)	62,122,904	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	93,412,675	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 5/25/2017 9:36 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		65,405,445		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,725,126				2.00
3.00	Total (sum of line 1 and line 2)		67,130,571		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)		67,130,571		0		11.00
12.00	DONOR RESTRICTED FUND	5,007,667		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)		5,007,667		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		62,122,904		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	DONOR RESTRICTED FUND		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: 15-0072 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/25/2017 9:36 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	9,304,112		9,304,112	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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)	9,304,112		9,304,112	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	927,912		927,912	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)	927,912		927,912	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	10,232,024		10,232,024	17.00
18.00	Ancillary services	21,863,706	86,140,802	108,004,508	18.00
19.00	Outpatient services	1,562,074	21,934,805	23,496,879	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	PHYSICIANS OFFICES	219	29,898,487	29,898,706	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	33,658,023	137,974,094	171,632,117	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		70,208,322		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)		70,208,322		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0072	Period: From 01/01/2016 To 12/31/2016	Worksheet G-3 Date/Time Prepared: 5/25/2017 9:36 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	171,632,117	1.00
2.00	Less contractual allowances and discounts on patients' accounts	101,923,318	2.00
3.00	Net patient revenues (line 1 minus line 2)	69,708,799	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	70,208,322	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-499,523	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 REVENUE	1,919,628	24.00
24.01	INVESTMENT INCOME	139,973	24.01
24.02	GAIN ON SALE OF EQUIPMENT	21,322	24.02
24.03	OTHER NON-OPERATING REVENUE	143,726	24.03
25.00	Total other income (sum of lines 6-24)	2,224,649	25.00
26.00	Total (line 5 plus line 25)	1,725,126	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,725,126	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0072	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 5/25/2017 9:36 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	324,290	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	10,344	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)	14.24	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	334,634	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