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: 15-0167	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 6/28/2017 9:43 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 6/28/2017 Time: 9:43 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ORTHOPAEDIC HOSPT.AT PARKVIEW (15-0167) 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	1,553	26,086	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	1,553	26,086	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 6/28/2017 9:42 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 11119 PARKVIEW PLAZA DRIVE	PO Box:			1.00
2.00	City: FORT WAYNE	State: IN	Zip Code: 46845-1705	County: ALLEN	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	ORTHOPAEDIC HOSPT.AT PARKVIEW	150167	23060	1	11/08/2007	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2016	12/31/2016	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 6/28/2017 9:42 am

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			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: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 6/28/2017 9:42 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: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 6/28/2017 9:42 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)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N				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:	251,450	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 6/28/2017 9:42 am

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H032	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: PARKVIEW HEALTH SYSTEM, INC.	Contractor's Name: WISCONSIN PHYSICIANS SERVICE	Contractor's Number: 08101	141.00
142.00	Street: 10501 CORPORATE DRIVE	PO Box: 5600		142.00
143.00	City: FORT WAYNE	State: IN	Zip Code: 46895-5600	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	N	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.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0167	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 6/28/2017 9:42 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)	10/01/2015	09/30/2016	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: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 6/28/2017 9:42 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.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 6/28/2017 9:42 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		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	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.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ERIC	NICKESON	41.00
42.00	Enter the employer/company name of the cost report preparer.	PARKVIEW HEALTH SYSTEM, INC.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(260) 373-8406	ERIC.NICKESON@PARKVIEW.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0167	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 6/28/2017 9:42 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.	DIRECTOR, REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 6/28/2017 9:42 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	37	13,542	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)		37	13,542	0.00	0	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)		37	13,542	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)	115.00					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)		37				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: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 6/28/2017 9:42 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)	843	256	5,494			1.00
2.00	HMO and other (see instructions)	1,337	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	843	256	5,494			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)	843	256	5,494	0.00	206.10	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				0.00	0.00	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	206.10	27.00
28.00	Observation Bed Days		28	366			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			148			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: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 6/28/2017 9:42 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	843	29	2,685	1.00
2.00	HMO and other (see instructions)			624	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	843	29	2,685	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)	0.00					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: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 6/28/2017 9:42 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	18,270,685	5,955,383	24,226,068	885,631.00	27.35	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		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	5,202,051	5,202,051	173,694.00	29.95	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		6,651,952	986,419	7,638,371	313,825.00	24.34	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		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	5,202,051	5,202,051	173,694.00	29.95	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)		3,428,175	0	3,428,175			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		2,462,838	0	2,462,838			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		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		1,590,724	0	1,590,724			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	2,736,510	-2,736,510	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	695,384	4,972,318	5,667,702	177,994.00	31.84	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 6/28/2017 9:42 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	133,779	299,018	432,797	17,855.00	24.24	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	204,181	43,138	247,319	17,859.00	13.85	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	258,167	258,167	6,602.00	39.10	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	0	0	0.00	0.00	38.00
39.00	Central Services and Supply	14.00	0	28,862	28,862	732.00	39.43	39.00
40.00	Pharmacy	15.00	0	16,363	16,363	418.00	39.15	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	185,804	0	185,804	6,698.00	27.74	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part III Date/Time Prepared: 6/28/2017 9:42 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)		18,270,685	753,332	19,024,017	711,937.00	26.72	1.00
2.00	Excluded area salaries (see instructions)		6,651,952	986,419	7,638,371	313,825.00	24.34	2.00
3.00	Subtotal salaries (line 1 minus line 2)		11,618,733	-233,087	11,385,646	398,112.00	28.60	3.00
4.00	Subtotal other wages & related costs (see inst.)		0	5,202,051	5,202,051	173,694.00	29.95	4.00
5.00	Subtotal wage-related costs (see inst.)		5,018,899	0	5,018,899	0.00	44.08	5.00
6.00	Total (sum of lines 3 thru 5)		16,637,632	4,968,964	21,606,596	571,806.00	37.79	6.00
7.00	Total overhead cost (see instructions)		3,955,658	2,881,356	6,837,014	228,158.00	29.97	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part IV Date/Time Prepared: 6/28/2017 9:42 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	331,566	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	568,400	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	76,845	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	3,327,638	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	32,556	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)	87,806	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	24,067	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	1,339,478	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	54,631	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	48,027	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,891,014	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: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part V Date/Time Prepared: 6/28/2017 9:42 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	5,891,014	1.00
2.00	Hospital	0	5,891,014	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC	0	0	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: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 6/28/2017 9:42 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)	0.183368	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	603,985	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?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	-345,729	5.00
6.00	Medicaid charges	9,589,968	6.00
7.00	Medicaid cost (line 1 times line 6)	1,758,493	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)	1,500,237	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)	4,062,860	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	25,084,653	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	4,599,723	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)	536,863	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)	2,037,100	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)	100,421	602,268	702,689	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	18,414	110,437	128,851	21.00
22.00	Partial payment by patients approved for charity care	0	3,736	3,736	22.00
23.00	Cost of charity care (line 21 minus line 22)	18,414	106,701	125,115	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,587,437	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	28,148	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,559,289	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	469,292	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	594,407	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,631,507	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 6/28/2017 9:42 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,477,224	2,477,224	-1,204,964	1,272,260	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	907,479	907,479	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,736,510	5,373,645	8,110,155	0	8,110,155	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	695,384	15,618,551	16,313,935	1,728	16,315,663	5.00
7.00	00700	OPERATION OF PLANT	133,779	1,358,535	1,492,314	-377	1,491,937	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	204,181	224,388	428,569	0	428,569	9.00
10.00	01000	DIETARY	0	258,167	258,167	0	258,167	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	28,862	28,862	0	28,862	14.00
15.00	01500	PHARMACY	0	16,363	16,363	0	16,363	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	185,804	15,904	201,708	0	201,708	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,172,179	267,617	2,439,796	-40,323	2,399,473	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,451,095	26,185,127	30,636,222	-22,753,281	7,882,941	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	499,381	499,381	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	348,776	348,776	-3,867	344,909	54.00
58.00	05800	MRI	318,248	0	318,248	0	318,248	58.00
60.00	06000	LABORATORY	0	445,710	445,710	0	445,710	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	25,538	25,538	0	25,538	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	76,587	76,587	0	76,587	65.00
66.00	06600	PHYSICAL THERAPY	659,604	28,532	688,136	0	688,136	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,401	1,401	0	1,401	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,066,034	3,066,034	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19,230,705	19,230,705	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,949	1,599,173	1,661,122	0	1,661,122	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	2,634,556	7,193,679	9,828,235	297,485	10,125,720	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,253,289	61,543,779	75,797,068	0	75,797,068	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	4,017,396	1,668,248	5,685,644	0	5,685,644	194.00
200.00		TOTAL (SUM OF LINES 118-199)	18,270,685	63,212,027	81,482,712	0	81,482,712	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 6/28/2017 9:42 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	1,272,260		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	907,479		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-263,396	7,846,759		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,590,441	18,906,104		5.00
7.00	00700	OPERATION OF PLANT	0	1,491,937		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0		8.00
9.00	00900	HOUSEKEEPING	0	428,569		9.00
10.00	01000	DIETARY	0	258,167		10.00
11.00	01100	CAFETERIA	0	0		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	0		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	28,862		14.00
15.00	01500	PHARMACY	0	16,363		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
17.00	01700	SOCIAL SERVICE	0	201,708		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,399,473		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	7,882,941		50.00
53.00	05300	ANESTHESIOLOGY	0	499,381		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	344,909		54.00
58.00	05800	MRI	0	318,248		58.00
60.00	06000	LABORATORY	0	445,710		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	25,538		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	76,587		65.00
66.00	06600	PHYSICAL THERAPY	0	688,136		66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,401		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,066,034		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	19,230,705		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,661,122		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	153,732	10,279,452		115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,480,777	78,277,845		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	70,631	5,756,275		194.00
200.00		TOTAL (SUM OF LINES 118-199)	2,551,408	84,034,120		200.00

RECLASSIFICATIONS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 6/28/2017 9:42 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - BUILDING DEPRECIATON				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	907,479	1.00
2.00	AMBULATORY SURGICAL CENTER (D.P.)	115.00	0	297,485	2.00
	0		0	1,204,964	
	B - MED AND IV SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	22,296,739	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	22,296,739	
	C - TELEPHONE EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,728	1.00
2.00		0.00	0	0	2.00
	0		0	1,728	
	D - BENEFITS ALLOCATION				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,736,510	1.00
	0		0	2,736,510	
	F - HOME OFFICE				
1.00	ADMINISTRATIVE & GENERAL	5.00	4,212,853	0	1.00
2.00	AMBULATORY SURGICAL CENTER (D.P.)	115.00	814,017	0	2.00
3.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	175,182	0	3.00
	0		5,202,052	0	
	H - PURCHASED SERVICES				
1.00	ADMINISTRATIVE & GENERAL	5.00	759,465	0	1.00
2.00	OPERATION OF PLANT	7.00	299,018	0	2.00
3.00	HOUSEKEEPING	9.00	43,138	0	3.00
4.00	DIETARY	10.00	258,167	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	28,862	0	5.00
6.00	PHARMACY	15.00	16,363	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	17,281	0	7.00
8.00	OPERATING ROOM	50.00	958,450	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	85,628	0	9.00
10.00	LABORATORY	60.00	445,710	0	10.00
11.00	RESPIRATORY THERAPY	65.00	76,587	0	11.00
12.00	PHYSICAL THERAPY	66.00	180	0	12.00
13.00	DRUGS CHARGED TO PATIENTS	73.00	503,772	0	13.00
	0		3,492,621	0	
	I - IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	19,230,705	1.00
	0		0	19,230,705	
	J - ANESTHESIA				
1.00	ANESTHESIOLOGY	53.00	0	499,381	1.00
	0		0	499,381	
	K - ASC BENEFITS				
1.00	AMBULATORY SURGICAL CENTER (D.P.)	115.00	0	2,780	1.00
	0		0	2,780	
500.00	Grand Total: Increases		8,694,673	45,972,807	500.00

RECLASSIFICATIONS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 6/28/2017 9:42 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - BUILDING DEPRECIATON						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,204,964	9		1.00
2.00		0.00	0	0	0		2.00
	0		0	1,204,964			
	B - MED AND IV SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	40,323	0		1.00
2.00	OPERATING ROOM	50.00	0	22,252,549	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,867	386		3.00
	0		0	22,296,739			
	C - TELEPHONE EXPENSE						
1.00	OPERATION OF PLANT	7.00	0	377	0		1.00
2.00	OPERATING ROOM	50.00	0	1,351	0		2.00
	0		0	1,728			
	D - BENEFITS ALLOCATION						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2,736,510	0	0		1.00
	0		2,736,510	0			
	F - HOME OFFICE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,212,853	0		1.00
2.00	AMBULATORY SURGICAL CENTER (D.P.)	115.00	0	814,017	0		2.00
3.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	0	175,182	0		3.00
	0		0	5,202,052			
	H - PURCHASED SERVICES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	759,465	0		1.00
2.00	OPERATION OF PLANT	7.00	0	299,018	0		2.00
3.00	HOUSEKEEPING	9.00	0	43,138	0		3.00
4.00	DIETARY	10.00	0	258,167	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	28,862	0		5.00
6.00	PHARMACY	15.00	0	16,363	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	17,281	0		7.00
8.00	OPERATING ROOM	50.00	0	958,450	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	85,628	0		9.00
10.00	LABORATORY	60.00	0	445,710	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	76,587	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	180	0		12.00
13.00	DRUGS CHARGED TO PATIENTS	73.00	0	503,772	0		13.00
	0		0	3,492,621			
	I - IMPLANTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	19,230,705	0		1.00
	0		0	19,230,705			
	J - ANESTHESIA						
1.00	OPERATING ROOM	50.00	0	499,381	0		1.00
	0		0	499,381			
	K - ASC BENEFITS						
1.00	AMBULATORY SURGICAL CENTER (D.P.)	115.00	2,780	0	0		1.00
	0		2,780	0			
500.00	Grand Total: Decreases		2,739,290	51,928,190			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 6/28/2017 9:42 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	9,446,043	0	0	0	0	3.00
4.00	Building Improvements	3,997,913	817,295	0	817,295	34,775	4.00
5.00	Fixed Equipment	8,786,262	0	0	0	0	5.00
6.00	Movable Equipment	11,041,661	1,610,506	0	1,610,506	754,072	6.00
7.00	HIT designated Assets	2,998,371	305,438	0	305,438	0	7.00
8.00	Subtotal (sum of lines 1-7)	36,270,250	2,733,239	0	2,733,239	788,847	8.00
9.00	Reconciling Items	1,053,968	-480,679	0	-480,679	0	9.00
10.00	Total (line 8 minus line 9)	35,216,282	3,213,918	0	3,213,918	788,847	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	9,446,043	672,131	3.00
4.00	Building Improvements	4,780,433	125,978	4.00
5.00	Fixed Equipment	8,786,262	44,171	5.00
6.00	Movable Equipment	11,898,095	2,964,866	6.00
7.00	HIT designated Assets	3,303,809	0	7.00
8.00	Subtotal (sum of lines 1-7)	38,214,642	3,807,146	8.00
9.00	Reconciling Items	573,289	0	9.00
10.00	Total (line 8 minus line 9)	37,641,353	3,807,146	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part II | Date/Time Prepared: 6/28/2017 9:42 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,477,224	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,477,224	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	2,477,224		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	2,477,224		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 6/28/2017 9:42 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	23,012,738	0	23,012,738	0.671003	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,898,095	614,782	11,283,313	0.328997	0	2.00
3.00	Total (sum of lines 1-2)	34,910,833	614,782	34,296,051	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,272,260	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	907,479	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,179,739	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,272,260	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	907,479	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	2,179,739	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 6/28/2017 9:42 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	0			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	2,506,796			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	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
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 OPERATING REVENUE	B	-33,731	ADMINISTRATIVE & GENERAL	5.00	0	33.00
35.00	SELF INSURANCE OFFSET	A	-263,396	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 6/28/2017 9:42 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	
36.00	NON ALLOWABLE LOBBY EXPENSE	A	-3,990	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	NET UPL ADD BACK	B	345,729	ADMINISTRATIVE & GENERAL	5.00	0	37.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		2,551,408				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 6/28/2017 9:42 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE COST REPORT	9,400,472	7,118,039	1.00
2.00	115.00	AMBULATORY SURGICAL CENTER (	HOME OFFICE COST REPORT	1,816,380	1,662,648	2.00
3.00	194.00	OTHER NONREIMBURSABLE COST C	HOME OFFICE COST REPORT	390,897	320,266	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			11,607,749	9,100,953	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	B		0.00	PARKVIEW HEALTH SYSTEM, INC	60.00	6.00
7.00	B		0.00	NORTHEAST ORTHOPAEDIC HOSPITAL INVE	40.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 6/28/2017 9:42 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	2,282,433	0		1.00
2.00	153,732	0		2.00
3.00	70,631	0		3.00
4.00	0	0		4.00
5.00	2,506,796			5.00

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

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

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

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

6.00	HEALTH SYSTEM		6.00
7.00	ORTHOPAEDIC SERVICES		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 6/28/2017 9:42 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,272,260	1,272,260				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	907,479		907,479			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,846,759	0	0	7,846,759		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,906,104	293,934	36,094	1,835,760	21,071,892	5.00
7.00	00700	OPERATION OF PLANT	1,491,937	0	56,749	140,182	1,688,868	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	428,569	0	0	80,106	508,675	9.00
10.00	01000	DIETARY	258,167	0	49	83,620	341,836	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28,862	0	0	9,348	38,210	14.00
15.00	01500	PHARMACY	16,363	0	0	5,300	21,663	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	201,708	0	0	60,181	261,889	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,399,473	351,207	65,493	709,160	3,525,333	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,882,941	583,743	321,715	1,752,135	10,540,534	50.00
53.00	05300	ANESTHESIOLOGY	499,381	0	0	0	499,381	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	344,909	0	0	27,735	372,644	54.00
58.00	05800	MRI	318,248	24,521	161,627	103,080	607,476	58.00
60.00	06000	LABORATORY	445,710	0	0	144,364	590,074	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	25,538	0	0	0	25,538	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	76,587	0	0	24,806	101,393	65.00
66.00	06600	PHYSICAL THERAPY	688,136	18,855	701	213,702	921,394	66.00
69.00	06900	ELECTROCARDIOLOGY	1,401	0	0	0	1,401	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,066,034	0	0	0	3,066,034	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,230,705	0	0	0	19,230,705	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,661,122	0	51,244	183,235	1,895,601	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	10,279,452	0	156,297	1,116,082	11,551,831	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	78,277,845	1,272,260	849,969	6,488,796	76,862,372	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	5,756,275	0	57,510	1,357,963	7,171,748	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	84,034,120	1,272,260	907,479	7,846,759	84,034,120	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 6/28/2017 9:42 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	21,071,892					5.00
7.00	00700	OPERATION OF PLANT	565,222	2,254,090				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	170,241	0	0	678,916		9.00
10.00	01000	DIETARY	114,404	0	0	0	456,240	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,788	0	0	0	0	14.00
15.00	01500	PHARMACY	7,250	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	87,648	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,179,841	809,189	0	243,722	456,240	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,527,653	1,344,963	0	405,094	0	50.00
53.00	05300	ANESTHESIOLOGY	167,130	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	124,715	0	0	0	0	54.00
58.00	05800	MRI	203,307	56,496	0	17,016	0	58.00
60.00	06000	LABORATORY	197,483	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,547	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	33,934	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	308,368	43,442	0	13,084	0	66.00
69.00	06900	ELECTROCARDIOLOGY	469	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,026,125	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,436,043	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	634,410	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	3,866,109	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,671,687	2,254,090	0	678,916	456,240	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	2,400,205	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	21,071,892	2,254,090	0	678,916	456,240	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 6/28/2017 9:42 am

		Cost Center Description	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	50,998		14.00
15.00	01500	PHARMACY	0	0	0	0	28,913	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	50,998	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	28,913	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	50,998	28,913	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	0	0	50,998	28,913	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 6/28/2017 9:42 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	
			16.00	17.00	19.00	20.00	21.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	0					16.00
17.00	01700	SOCIAL SERVICE	0	349,537				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	349,537	0	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	349,537	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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)	0	349,537	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 6/28/2017 9:42 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			22.00	23.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	6,563,862	0	6,563,862	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	15,818,244	0	15,818,244	50.00
53.00	05300	ANESTHESIOLOGY	0	0	666,511	0	666,511	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	497,359	0	497,359	54.00
58.00	05800	MRI	0	0	884,295	0	884,295	58.00
60.00	06000	LABORATORY	0	0	787,557	0	787,557	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	34,085	0	34,085	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	135,327	0	135,327	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,286,288	0	1,286,288	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,870	0	1,870	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	4,092,159	0	4,092,159	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	25,717,746	0	25,717,746	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,558,924	0	2,558,924	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	15,417,940	0	15,417,940	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	74,462,167	0	74,462,167	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	9,571,953	0	9,571,953	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	0	84,034,120	0	84,034,120	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 6/28/2017 9:42 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	293,934	36,094	330,028	0	5.00
7.00	00700	OPERATION OF PLANT	0	0	56,749	56,749	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	0	49	49	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	351,207	65,493	416,700	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	583,743	321,715	905,458	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
58.00	05800	MRI	0	24,521	161,627	186,148	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	18,855	701	19,556	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	51,244	51,244	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	156,297	156,297	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,272,260	849,969	2,122,229	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	57,510	57,510	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,272,260	907,479	2,179,739	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 6/28/2017 9:42 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	330,028					5.00
7.00	00700	OPERATION OF PLANT	8,853	65,602				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	2,666	0	0	2,666		9.00
10.00	01000	DIETARY	1,792	0	0	0	1,841	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	200	0	0	0	0	14.00
15.00	01500	PHARMACY	114	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,373	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,480	23,550	0	957	1,841	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	55,253	39,144	0	1,591	0	50.00
53.00	05300	ANESTHESIOLOGY	2,618	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,953	0	0	0	0	54.00
58.00	05800	MRI	3,184	1,644	0	67	0	58.00
60.00	06000	LABORATORY	3,093	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	134	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	532	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,830	1,264	0	51	0	66.00
69.00	06900	ELECTROCARDIOLOGY	7	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,072	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	100,788	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,937	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	60,555	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	292,434	65,602	0	2,666	1,841	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	37,594	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	330,028	65,602	0	2,666	1,841	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 6/28/2017 9:42 am

		Cost Center Description	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	200		14.00
15.00	01500	PHARMACY	0	0	0	0	114	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	200	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	114	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	200	114	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	0	0	200	114	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 6/28/2017 9:42 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	
			16.00	17.00	19.00	20.00	21.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	0					16.00
17.00	01700	SOCIAL SERVICE	0	1,373				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,373				30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0				50.00
53.00	05300	ANESTHESIOLOGY	0	0				53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0				54.00
58.00	05800	MRI	0	0				58.00
60.00	06000	LABORATORY	0	0				60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30
65.00	06500	RESPIRATORY THERAPY	0	0				65.00
66.00	06600	PHYSICAL THERAPY	0	0				66.00
69.00	06900	ELECTROCARDIOLOGY	0	0				69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0				73.00
76.97	07697	CARDIAC REHABILITATION	0	0				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0				76.98
76.99	07699	LITHOTRIPSY	0	0				76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0				90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0				115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,373	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0				194.00
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)	0	1,373	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 6/28/2017 9:42 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			22.00	23.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS			462,901	0	462,901	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM			1,001,446	0	1,001,446	50.00
53.00	05300	ANESTHESIOLOGY			2,618	0	2,618	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC			1,953	0	1,953	54.00
58.00	05800	MRI			191,043	0	191,043	58.00
60.00	06000	LABORATORY			3,093	0	3,093	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL			134	0	134	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS			0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY			532	0	532	65.00
66.00	06600	PHYSICAL THERAPY			25,701	0	25,701	66.00
69.00	06900	ELECTROCARDIOLOGY			7	0	7	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT			16,072	0	16,072	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS			100,988	0	100,988	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS			61,295	0	61,295	73.00
76.97	07697	CARDIAC REHABILITATION			0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY			0	0	0	76.98
76.99	07699	LITHOTRIPSY			0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC			0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			216,852	0	216,852	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	2,084,635	0	2,084,635	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS			95,104	0	95,104	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	0	2,179,739	0	2,179,739	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 6/28/2017 9:42 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	80,837					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,728,154				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	24,226,068			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,676	68,735	5,667,702	-21,071,892	62,962,228	5.00
7.00	00700	OPERATION OF PLANT	0	108,070	432,797	0	1,688,868	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	247,319	0	508,675	9.00
10.00	01000	DIETARY	0	93	258,167	0	341,836	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	28,862	0	38,210	14.00
15.00	01500	PHARMACY	0	0	16,363	0	21,663	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	185,804	0	261,889	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,315	124,721	2,189,460	0	3,525,333	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,090	612,658	5,409,545	0	10,540,534	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	499,381	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	85,628	0	372,644	54.00
58.00	05800	MRI	1,558	307,794	318,248	0	607,476	58.00
60.00	06000	LABORATORY	0	0	445,710	0	590,074	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	25,538	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	76,587	0	101,393	65.00
66.00	06600	PHYSICAL THERAPY	1,198	1,335	659,784	0	921,394	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	1,401	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	3,066,034	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	19,230,705	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	97,586	565,721	0	1,895,601	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	297,644	3,445,793	0	11,551,831	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	80,837	1,618,636	20,033,490	-21,071,892	55,790,480	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	109,518	4,192,578	0	7,171,748	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,272,260	907,479	7,846,759		21,071,892	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.738585	0.525115	0.323897		0.334675	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		330,028	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.005242	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 6/28/2017 9:42 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	62,161					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0				8.00
9.00	00900	HOUSEKEEPING	0	0	62,161			9.00
10.00	01000	DIETARY	0	0	0	23,599		10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,315	0	22,315	23,599	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,090	0	37,090	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
58.00	05800	MRI	1,558	0	1,558	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,198	0	1,198	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	62,161	0	62,161	23,599	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,254,090	0	678,916	456,240	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	36.262126	0.000000	10.921896	19.333023	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	65,602	0	2,666	1,841	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.055356	0.000000	0.042889	0.078012	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 6/28/2017 9:42 am

		Cost Center Description	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			12.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	0				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	19,744,212			14.00
15.00	01500	PHARMACY	0	0	0	10,000		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	19,744,212	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,000	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	19,744,212	10,000	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0	50,998	28,913	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	0.002583	2.891300	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	200	114	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000010	0.011400	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 6/28/2017 9:42 am

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
			17.00	19.00	20.00	21.00	22.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	10,000					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
20.00	02000	NURSING SCHOOL	0		0			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0			0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0				0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,000	0	0	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,000	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	349,537	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	34.953700	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,373	0	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.137300	0.000000	0.000000	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 6/28/2017 9:42 am

		Cost Center Description	PARAMED ED PRGM (ASSIGNED TIME)		
			23.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
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			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
58.00	05800	MRI	0		58.00
60.00	06000	LABORATORY	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62.30
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.97	07697	CARDIAC REHABILITATION	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		76.98
76.99	07699	LITHOTRIPSY	0		76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0		194.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 6/28/2017 9:42 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	6,563,862		6,563,862	0	6,563,862	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,818,244		15,818,244	0	15,818,244	50.00
53.00	05300	ANESTHESIOLOGY	666,511		666,511	0	666,511	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	497,359		497,359	0	497,359	54.00
58.00	05800	MRI	884,295		884,295	0	884,295	58.00
60.00	06000	LABORATORY	787,557		787,557	0	787,557	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	34,085		34,085	0	34,085	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	135,327	0	135,327	0	135,327	65.00
66.00	06600	PHYSICAL THERAPY	1,286,288	0	1,286,288	0	1,286,288	66.00
69.00	06900	ELECTROCARDIOLOGY	1,870		1,870	0	1,870	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,092,159		4,092,159	0	4,092,159	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,717,746		25,717,746	0	25,717,746	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,558,924		2,558,924	0	2,558,924	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	409,960		409,960		409,960	92.00
		SPECIAL PURPOSE COST CENTERS						
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	15,417,940		15,417,940		15,417,940	115.00
200.00		Subtotal (see instructions)	74,872,127	0	74,872,127	0	74,872,127	200.00
201.00		Less Observation Beds	409,960		409,960		409,960	201.00
202.00		Total (see instructions)	74,462,167	0	74,462,167	0	74,462,167	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 6/28/2017 9:42 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	7,934,664		7,934,664			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	80,134,151	67,798,792	147,932,943	0.106928	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	6,999,437	5,596,282	12,595,719	0.052916	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,273,883	1,496,441	2,770,324	0.179531	0.000000	54.00
58.00	05800	MRI	40,830	9,676,168	9,716,998	0.091005	0.000000	58.00
60.00	06000	LABORATORY	1,760,760	288,403	2,049,163	0.384331	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	130,841	0	130,841	0.260507	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	597,957	222,160	820,117	0.165009	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,072,811	71,615	4,144,426	0.310366	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	38,805	0	38,805	0.048190	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,398,720	22,916,990	31,315,710	0.130674	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	82,882,061	18,046,583	100,928,644	0.254811	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,218,218	4,174,526	16,392,744	0.156101	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	274,427	274,427	1.493876	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	69,034,397	69,034,397			115.00
200.00		Subtotal (see instructions)	206,483,138	199,596,784	406,079,922			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	206,483,138	199,596,784	406,079,922			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 6/28/2017 9:42 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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.106928	50.00
53.00	05300	ANESTHESIOLOGY	0.052916	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179531	54.00
58.00	05800	MRI	0.091005	58.00
60.00	06000	LABORATORY	0.384331	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.260507	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0.165009	65.00
66.00	06600	PHYSICAL THERAPY	0.310366	66.00
69.00	06900	ELECTROCARDIOLOGY	0.048190	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.130674	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.254811	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.156101	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.493876	92.00
		SPECIAL PURPOSE COST CENTERS		
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)		115.00
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: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 6/28/2017 9:42 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,563,862		6,563,862	0	6,563,862	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,818,244		15,818,244	0	15,818,244	50.00
53.00	05300	ANESTHESIOLOGY	666,511		666,511	0	666,511	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	497,359		497,359	0	497,359	54.00
58.00	05800	MRI	884,295		884,295	0	884,295	58.00
60.00	06000	LABORATORY	787,557		787,557	0	787,557	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	34,085		34,085	0	34,085	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	135,327	0	135,327	0	135,327	65.00
66.00	06600	PHYSICAL THERAPY	1,286,288	0	1,286,288	0	1,286,288	66.00
69.00	06900	ELECTROCARDIOLOGY	1,870		1,870	0	1,870	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,092,159		4,092,159	0	4,092,159	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,717,746		25,717,746	0	25,717,746	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,558,924		2,558,924	0	2,558,924	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	409,960		409,960		409,960	92.00
		SPECIAL PURPOSE COST CENTERS						
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	15,417,940		15,417,940		15,417,940	115.00
200.00		Subtotal (see instructions)	74,872,127	0	74,872,127	0	74,872,127	200.00
201.00		Less Observation Beds	409,960		409,960		409,960	201.00
202.00		Total (see instructions)	74,462,167	0	74,462,167	0	74,462,167	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 6/28/2017 9:42 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,934,664		7,934,664			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	80,134,151	67,798,792	147,932,943	0.106928	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	6,999,437	5,596,282	12,595,719	0.052916	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,273,883	1,496,441	2,770,324	0.179531	0.000000	54.00
58.00	05800	MRI	40,830	9,676,168	9,716,998	0.091005	0.000000	58.00
60.00	06000	LABORATORY	1,760,760	288,403	2,049,163	0.384331	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	130,841	0	130,841	0.260507	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	597,957	222,160	820,117	0.165009	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,072,811	71,615	4,144,426	0.310366	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	38,805	0	38,805	0.048190	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,398,720	22,916,990	31,315,710	0.130674	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	82,882,061	18,046,583	100,928,644	0.254811	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,218,218	4,174,526	16,392,744	0.156101	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	274,427	274,427	1.493876	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	69,034,397	69,034,397			115.00
200.00		Subtotal (see instructions)	206,483,138	199,596,784	406,079,922			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	206,483,138	199,596,784	406,079,922			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 6/28/2017 9:42 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.106928	50.00
53.00	05300	ANESTHESIOLOGY	0.052916	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179531	54.00
58.00	05800	MRI	0.091005	58.00
60.00	06000	LABORATORY	0.384331	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.260507	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0.165009	65.00
66.00	06600	PHYSICAL THERAPY	0.310366	66.00
69.00	06900	ELECTROCARDIOLOGY	0.048190	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.130674	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.254811	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.156101	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.493876	92.00
		SPECIAL PURPOSE COST CENTERS		
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)		115.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part II Date/Time Prepared: 6/28/2017 9:42 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,818,244	1,001,446	14,816,798	0	0	50.00
53.00	05300	ANESTHESIOLOGY	666,511	2,618	663,893	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	497,359	1,953	495,406	0	0	54.00
58.00	05800	MRI	884,295	191,043	693,252	0	0	58.00
60.00	06000	LABORATORY	787,557	3,093	784,464	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	34,085	134	33,951	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	135,327	532	134,795	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,286,288	25,701	1,260,587	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,870	7	1,863	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,092,159	16,072	4,076,087	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,717,746	100,988	25,616,758	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,558,924	61,295	2,497,629	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	409,960	28,912	381,048	0	0	92.00
		SPECIAL PURPOSE COST CENTERS						
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	15,417,940	216,852	15,201,088	0	0	115.00
200.00		Subtotal (sum of lines 50 thru 199)	68,308,265	1,650,646	66,657,619	0	0	200.00
201.00		Less Observation Beds	409,960	28,912	381,048	0	0	201.00
202.00		Total (line 200 minus line 201)	67,898,305	1,621,734	66,276,571	0	0	202.00

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

Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part II Date/Time Prepared: 6/28/2017 9:42 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	15,818,244	147,932,943	0.106928		50.00
53.00	05300	ANESTHESIOLOGY	666,511	12,595,719	0.052916		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	497,359	2,770,324	0.179531		54.00
58.00	05800	MRI	884,295	9,716,998	0.091005		58.00
60.00	06000	LABORATORY	787,557	2,049,163	0.384331		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	34,085	130,841	0.260507		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	135,327	820,117	0.165009		65.00
66.00	06600	PHYSICAL THERAPY	1,286,288	4,144,426	0.310366		66.00
69.00	06900	ELECTROCARDIOLOGY	1,870	38,805	0.048190		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,092,159	31,315,710	0.130674		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,717,746	100,928,644	0.254811		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,558,924	16,392,744	0.156101		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000		76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000		76.99
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0.000000		90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	409,960	274,427	1.493876		92.00
		SPECIAL PURPOSE COST CENTERS					
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	15,417,940	69,034,397	0.223337		115.00
200.00		Subtotal (sum of lines 50 thru 199)	68,308,265	398,145,258			200.00
201.00		Less Observation Beds	409,960	0			201.00
202.00		Total (line 200 minus line 201)	67,898,305	398,145,258			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part I Date/Time Prepared: 6/28/2017 9:42 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	462,901	0	462,901	5,860	78.99	30.00
200.00	Total (lines 30-199)	462,901		462,901	5,860		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	843	66,589	30.00
200.00	Total (lines 30-199)	843	66,589	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 6/28/2017 9:42 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,001,446	147,932,943	0.006770	24,753,803	167,583	50.00
53.00	05300	ANESTHESIOLOGY	2,618	12,595,719	0.000208	2,222,581	462	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,953	2,770,324	0.000705	796,239	561	54.00
58.00	05800	MRI	191,043	9,716,998	0.019661	13,440	264	58.00
60.00	06000	LABORATORY	3,093	2,049,163	0.001509	717,406	1,083	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	134	130,841	0.001024	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	532	820,117	0.000649	198,317	129	65.00
66.00	06600	PHYSICAL THERAPY	25,701	4,144,426	0.006201	1,331,039	8,254	66.00
69.00	06900	ELECTROCARDIOLOGY	7	38,805	0.000180	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,072	31,315,710	0.000513	2,673,020	1,371	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	100,988	100,928,644	0.001001	26,057,851	26,084	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,295	16,392,744	0.003739	3,938,157	14,725	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	28,912	274,427	0.105354	0	0	92.00
200.00		Total (lines 50-199)	1,433,794	329,110,861		62,701,853	220,516	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 6/28/2017 9:42 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
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	5,860	0.00	843	0		30.00
200.00		Total (lines 30-199)	5,860		843	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 6/28/2017 9:42 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 6/28/2017 9:42 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	147,932,943	0.000000	0.000000	24,753,803	50.00
53.00	05300	ANESTHESIOLOGY	0	12,595,719	0.000000	0.000000	2,222,581	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,770,324	0.000000	0.000000	796,239	54.00
58.00	05800	MRI	0	9,716,998	0.000000	0.000000	13,440	58.00
60.00	06000	LABORATORY	0	2,049,163	0.000000	0.000000	717,406	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	130,841	0.000000	0.000000	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	820,117	0.000000	0.000000	198,317	65.00
66.00	06600	PHYSICAL THERAPY	0	4,144,426	0.000000	0.000000	1,331,039	66.00
69.00	06900	ELECTROCARDIOLOGY	0	38,805	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	31,315,710	0.000000	0.000000	2,673,020	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	100,928,644	0.000000	0.000000	26,057,851	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,392,744	0.000000	0.000000	3,938,157	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	274,427	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	329,110,861			62,701,853	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 6/28/2017 9:42 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	4,348,521	0		50.00
53.00	05300	ANESTHESIOLOGY	0	341,003	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	72,021	0		54.00
58.00	05800	MRI	0	817,112	0		58.00
60.00	06000	LABORATORY	0	4,742	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	3,432	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	568,004	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,138,794	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	290,905	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	17,200	0		92.00
200.00		Total (lines 50-199)	0	7,601,734	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 6/28/2017 9:42 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	0.106928	4,348,521	0	0	464,979	50.00
53.00	05300	ANESTHESIOLOGY	0.052916	341,003	0	0	18,045	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179531	72,021	0	0	12,930	54.00
58.00	05800	MRI	0.091005	817,112	0	0	74,361	58.00
60.00	06000	LABORATORY	0.384331	4,742	0	0	1,822	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.260507	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.165009	3,432	0	0	566	65.00
66.00	06600	PHYSICAL THERAPY	0.310366	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.048190	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.130674	568,004	0	0	74,223	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.254811	1,138,794	0	0	290,177	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.156101	290,905	0	0	45,411	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.493876	17,200	0	0	25,695	92.00
200.00		Subtotal (see instructions)		7,601,734	0	0	1,008,209	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		7,601,734	0	0	1,008,209	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 6/28/2017 9:42 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
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part I Date/Time Prepared: 6/28/2017 9:42 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	462,901	0	462,901	5,860	78.99	30.00
200.00	Total (lines 30-199)	462,901		462,901	5,860		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	256	20,221	30.00
200.00	Total (lines 30-199)	256	20,221	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 6/28/2017 9:42 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,001,446	147,932,943	0.006770	160,064	1,084	50.00
53.00	05300	ANESTHESIOLOGY	2,618	12,595,719	0.000208	15,502	3	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,953	2,770,324	0.000705	3,598	3	54.00
58.00	05800	MRI	191,043	9,716,998	0.019661	0	0	58.00
60.00	06000	LABORATORY	3,093	2,049,163	0.001509	5,558	8	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	134	130,841	0.001024	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	532	820,117	0.000649	1,603	1	65.00
66.00	06600	PHYSICAL THERAPY	25,701	4,144,426	0.006201	10,015	62	66.00
69.00	06900	ELECTROCARDIOLOGY	7	38,805	0.000180	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,072	31,315,710	0.000513	15,900	8	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	100,988	100,928,644	0.001001	184,500	185	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,295	16,392,744	0.003739	25,318	95	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	28,912	274,427	0.105354	0	0	92.00
200.00		Total (lines 50-199)	1,433,794	329,110,861		422,058	1,449	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 6/28/2017 9:42 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
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	5,860	0.00	256	0		30.00
200.00		Total (lines 30-199)	5,860		256	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 6/28/2017 9:42 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 6/28/2017 9:42 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	147,932,943	0.000000	0.000000	160,064	50.00
53.00	05300	ANESTHESIOLOGY	0	12,595,719	0.000000	0.000000	15,502	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,770,324	0.000000	0.000000	3,598	54.00
58.00	05800	MRI	0	9,716,998	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	2,049,163	0.000000	0.000000	5,558	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	130,841	0.000000	0.000000	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	820,117	0.000000	0.000000	1,603	65.00
66.00	06600	PHYSICAL THERAPY	0	4,144,426	0.000000	0.000000	10,015	66.00
69.00	06900	ELECTROCARDIOLOGY	0	38,805	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	31,315,710	0.000000	0.000000	15,900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	100,928,644	0.000000	0.000000	184,500	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,392,744	0.000000	0.000000	25,318	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	274,427	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	329,110,861			422,058	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 6/28/2017 9:42 am

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 6/28/2017 9:42 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.106928	0	0	346,718	0	50.00
53.00	05300	ANESTHESIOLOGY	0.052916	0	0	27,901	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179531	0	0	7,659	0	54.00
58.00	05800	MRI	0.091005	0	0	34,353	0	58.00
60.00	06000	LABORATORY	0.384331	0	0	1,829	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.260507	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.165009	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.310366	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.048190	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.130674	0	0	19,984	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.254811	0	0	56,877	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.156101	0	0	20,639	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.493876	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	515,960	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	515,960	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 6/28/2017 9:42 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	37,074		50.00
53.00	05300	ANESTHESIOLOGY	0	1,476		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,375		54.00
58.00	05800	MRI	0	3,126		58.00
60.00	06000	LABORATORY	0	703		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,611		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,493		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,222		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	64,080		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	64,080		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 6/28/2017 9:42 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)	5,860	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,860	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,494	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)	843	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)	6,563,862	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)	6,563,862	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)	6,563,862	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)	1,120.11	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	944,253	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)	944,253	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 6/28/2017 9:42 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	11,234,083	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	12,178,336	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)	66,589	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	220,516	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	287,105	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	11,891,231	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)	366	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,120.11	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	409,960	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 6/28/2017 9:42 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	462,901	6,563,862	0.070523	409,960	28,912	90.00
91.00	Nursing School cost	0	6,563,862	0.000000	409,960	0	91.00
92.00	Allied health cost	0	6,563,862	0.000000	409,960	0	92.00
93.00	All other Medical Education	0	6,563,862	0.000000	409,960	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 6/28/2017 9:42 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,860	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,860	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,494	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)	256	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)	6,563,862	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)	6,563,862	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)	6,563,862	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)	1,120.11	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	286,748	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)	286,748	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 6/28/2017 9:42 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	77,133	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	363,881	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)	20,221	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,449	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	21,670	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	342,211	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)	366	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,120.11	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	409,960	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 6/28/2017 9:42 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	462,901	6,563,862	0.070523	409,960	28,912	90.00
91.00	Nursing School cost	0	6,563,862	0.000000	409,960	0	91.00
92.00	Allied health cost	0	6,563,862	0.000000	409,960	0	92.00
93.00	All other Medical Education	0	6,563,862	0.000000	409,960	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 6/28/2017 9:42 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		2,660,858		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.106928	24,753,803	2,646,875	50.00
53.00	05300	ANESTHESIOLOGY	0.052916	2,222,581	117,610	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179531	796,239	142,950	54.00
58.00	05800	MRI	0.091005	13,440	1,223	58.00
60.00	06000	LABORATORY	0.384331	717,406	275,721	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.260507	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.165009	198,317	32,724	65.00
66.00	06600	PHYSICAL THERAPY	0.310366	1,331,039	413,109	66.00
69.00	06900	ELECTROCARDIOLOGY	0.048190	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.130674	2,673,020	349,294	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.254811	26,057,851	6,639,827	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.156101	3,938,157	614,750	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.493876	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		62,701,853	11,234,083	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)		62,701,853		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 6/28/2017 9:42 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		17,043		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.106928	160,064	17,115	50.00
53.00	05300	ANESTHESIOLOGY	0.052916	15,502	820	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179531	3,598	646	54.00
58.00	05800	MRI	0.091005	0	0	58.00
60.00	06000	LABORATORY	0.384331	5,558	2,136	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.260507	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.165009	1,603	265	65.00
66.00	06600	PHYSICAL THERAPY	0.310366	10,015	3,108	66.00
69.00	06900	ELECTROCARDIOLOGY	0.048190	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.130674	15,900	2,078	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.254811	184,500	47,013	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.156101	25,318	3,952	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.493876	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		422,058	77,133	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)		422,058		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0167	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 6/28/2017 9:42 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)	7,843,910	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,764,932	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)	30,482	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	7,766,389	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	36.00	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)	0.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)	0.00	31.00
32.00	Sum of lines 30 and 31	0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)	0.00	33.00
34.00	Disproportionate share adjustment (see instructions)	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0167	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 6/28/2017 9:42 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000004054	0.000004773	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	0		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)	10,639,324		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	10,639,324	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	846,110	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)	11,485,434	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	11,485,434	61.00
62.00	Deductibles billed to program beneficiaries	1,059,940	62.00
63.00	Coinsurance billed to program beneficiaries	0	63.00
64.00	Allowable bad debts (see instructions)	2,434	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	1,582	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	2,434	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	10,427,076	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)	115,092	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: 15-0167	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 6/28/2017 9:42 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)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		10,542,168	71.00
71.01	Sequestration adjustment (see instructions)		210,843	71.01
72.00	Interim payments		10,329,772	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)		1,553	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0167	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 6/28/2017 9:42 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	1,008,209	2.00
3.00	PPS payments	1,734,629	3.00
4.00	Outlier payment (see instructions)	24,928	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)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	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)	1,759,557	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	363,487	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	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)	1,396,070	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)	1,396,070	30.00
31.00	Primary payer payments	1,006	31.00
32.00	Subtotal (line 30 minus line 31)	1,395,064	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)	40,871	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	26,566	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	40,871	36.00
37.00	Subtotal (see instructions)	1,421,630	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,421,630	40.00
40.01	Sequestration adjustment (see instructions)	28,433	40.01
41.00	Interim payments	1,367,111	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	26,086	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: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 6/28/2017 9:42 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		10,329,772		1,367,111	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)		10,329,772		1,367,111	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		1,553		26,086	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		10,331,325		1,393,197	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: 15-0167	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 6/28/2017 9:42 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	2,685	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	843	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,337	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	5,494	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	406,079,922	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	702,689	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

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

Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 6/28/2017 9:42 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	4,199,463	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	20,202,524	0	0	0	4.00
5.00	Other receivable	17,571	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	919	0	0	0	7.00
8.00	Prepaid expenses	-905,808	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	23,514,669	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	9,446,043	0	0	0	15.00
16.00	Accumulated depreciation	-2,336,883	0	0	0	16.00
17.00	Leasehold improvements	4,780,432	0	0	0	17.00
18.00	Accumulated depreciation	-1,630,752	0	0	0	18.00
19.00	Fixed equipment	157,301	0	0	0	19.00
20.00	Accumulated depreciation	-80,217	0	0	0	20.00
21.00	Automobiles and trucks	21,045	0	0	0	21.00
22.00	Accumulated depreciation	-7,453	0	0	0	22.00
23.00	Major movable equipment	20,506,011	0	0	0	23.00
24.00	Accumulated depreciation	-11,368,832	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)	19,486,695	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	58,289,927	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	58,289,927	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	101,291,291	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	5,298,242	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	7,580,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,282,186	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,160,428	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	631,667	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	9,801,267	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10,432,934	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	24,593,362	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	76,697,929				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)	76,697,929	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	101,291,291	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 6/28/2017 9:42 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		201,054,792		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		76,543,137				2.00
3.00	Total (sum of line 1 and line 2)		277,597,929		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)		277,597,929		0		11.00
12.00	TRANSFERS	200,900,000		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)		200,900,000		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		76,697,929		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	TRANSFERS		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: 15-0167 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 6/28/2017 9:42 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,899,360		7,899,360	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7,899,360		7,899,360	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	7,899,360		7,899,360	17.00
18.00	Ancillary services	203,123,993	120,754,525	323,878,518	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	87,157,155	87,157,155	25.00
26.00	HOSPICE				26.00
27.00	THERAPY REVENUE	0	6,108,596	6,108,596	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	211,023,353	214,020,276	425,043,629	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		81,482,712		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)		81,482,712		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0167	Period: From 01/01/2016 To 12/31/2016	Worksheet G-3 Date/Time Prepared: 6/28/2017 9:42 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	425,043,629	1.00
2.00	Less contractual allowances and discounts on patients' accounts	268,431,135	2.00
3.00	Net patient revenues (line 1 minus line 2)	156,612,494	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	81,482,712	4.00
5.00	Net income from service to patients (line 3 minus line 4)	75,129,782	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	200	6.00
7.00	Income from investments	-11,562	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 OPERATING REVENUES	1,441,534	24.00
25.00	Total other income (sum of lines 6-24)	1,430,172	25.00
26.00	Total (line 5 plus line 25)	76,559,954	26.00
27.00	GAIN ON SALE OF ASSET	16,817	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	16,817	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	76,543,137	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0167	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 6/28/2017 9:42 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	845,006	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	1,104	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)	15.42	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)	846,110	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