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: 15-0035	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/30/2017 10:22 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/30/2017 Time: 10:22 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 PORTER MEMORIAL HOSPITAL (15-0035) 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.

Encryption Information

ECR: Date: 5/30/2017 Time: 10:22 am
5UajDnmTDBOMdDY6LYiybiA.4QYle0
vaH000o3025RWjTB.9adMOM.Hh57QA
nWfg0Cru.S0CRKeV

PI: Date: 5/30/2017 Time: 10:22 am
y5wG1ddWcempBioB2RWUNO:1FXuKU0
wZeCP038oRQgrN5CtvStDaHbm6bOrw
klDI0Os6Kt0bGtex

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

Senior Vice President, Revenue Management
Title

5/30/17
Date

		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	231,828	-78,664	619,622	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	-15,005	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	216,823	-78,664	619,622	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: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 10:19 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 85 EAST US HIGHWAY 6	PO Box:			1.00
2.00	City: VALPARAISO	State: IN	Zip Code: 46383	County: PORTER	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	PORTER MEMORIAL HOSPITAL	150035	23844	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	PORTER REHAB UNIT	15T035	23844	5	01/01/2009	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2016	12/31/2016	20.00
21.00	Type of Control (see instructions)	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.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	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.	1,705	418	14	91	7,822	181	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	9	0	0	117		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 10:19 am

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	Y			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: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 10:19 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: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 10:19 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.	Y			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N		0	76.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2017 10:19 am

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	740,179	761,368	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: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2017 10:19 am

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	449008	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: CHS/COMMUNITY HEALTH SYSTEMS INC	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		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)	0.25	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0035	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 10:19 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)	04/01/2016	06/29/2016	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: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2017 10:19 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)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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?		Y	Y	6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/17/2017	Y	04/17/2017
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 10:19 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	Y	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.	Y	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	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	12/31/2015	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.	VICTORIA	ROMANKO	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-925-4333	VICTORIA_ROMANKO@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0035	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 10:19 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REVENUE MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2017 10:19 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	192	70,272	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)		192	70,272	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	32	11,712	0.00	0	8.00
8.01	NEONATAL INTENSIVE CARE UNIT	31.01	14	5,124	0.00	0	8.01
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		238	87,108	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	14	5,124		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		252				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: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2017 10:19 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)	23,301	981	46,541			1.00
2.00	HMO and other (see instructions)	6,251	7,489				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	117				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)	23,301	981	46,541			7.00
8.00	INTENSIVE CARE UNIT	3,650	579	6,917			8.00
8.01	NEONATAL INTENSIVE CARE UNIT	0	0	2,388			8.01
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		1,001	1,001			13.00
14.00	Total (see instructions)	26,951	2,561	56,847	0.00	1,494.78	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	1,719	9	2,607	0.00	13.41	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.)						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	1,508.19	27.00
28.00	Observation Bed Days		0	4,018			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	181	544			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: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2017 10:19 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	4,976	1,538	12,366	1.00
2.00	HMO and other (see instructions)			0	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
8.01	NEONATAL INTENSIVE CARE UNIT						8.01
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	4,976	1,538	12,366	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	142	15	210	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.)						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: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2017 10:19 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	90,107,045	0	90,107,045	3,137,032.00	28.72	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		257,076	0	257,076	1,664.00	154.49	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,014,325	351,313	1,365,638	39,984.00	34.15	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,697,519	0	2,697,519	27,545.00	97.93	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		678,303	0	678,303	6,797.00	99.79	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		8,349,858	0	8,349,858	243,341.00	34.31	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)		24,414,158	0	24,414,158			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		343,558	0	343,558			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		23,379	0	23,379			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		0	0	0			25.50
25.51	Related orgainzation wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	321,550	0	321,550	8,556.00	37.58	26.00
27.00	Administrative & General	5.00	8,350,826	-598,584	7,752,242	320,096.00	24.22	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2017 10:19 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.)		980,894	0	980,894	42,837.00	22.90	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,642,527	0	1,642,527	58,426.00	28.11	30.00
31.00	Laundry & Linen Service	8.00	128,279	0	128,279	8,945.00	14.34	31.00
32.00	Housekeeping	9.00	1,931,238	0	1,931,238	163,714.00	11.80	32.00
33.00	Housekeeping under contract (see instructions)		370,906	0	370,906	6,148.00	60.33	33.00
34.00	Dietary	10.00	2,020,940	-1,141,703	879,237	61,466.00	14.30	34.00
35.00	Dietary under contract (see instructions)		440,471	0	440,471	11,544.00	38.16	35.00
36.00	Cafeteria	11.00	0	1,141,703	1,141,703	79,815.00	14.30	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	3,549,721	247,271	3,796,992	95,368.00	39.81	38.00
39.00	Central Services and Supply	14.00	972,188	0	972,188	64,017.00	15.19	39.00
40.00	Pharmacy	15.00	2,704,036	0	2,704,036	58,235.00	46.43	40.00
41.00	Medical Records & Medical Records Library	16.00	973,294	0	973,294	44,223.00	22.01	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part III Date/Time Prepared: 5/30/2017 10:19 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)		91,899,316	0	91,899,316	3,197,561.00	28.74	1.00
2.00	Excluded area salaries (see instructions)		1,014,325	351,313	1,365,638	39,984.00	34.15	2.00
3.00	Subtotal salaries (line 1 minus line 2)		90,884,991	-351,313	90,533,678	3,157,577.00	28.67	3.00
4.00	Subtotal other wages & related costs (see inst.)		11,725,680	0	11,725,680	277,683.00	42.23	4.00
5.00	Subtotal wage-related costs (see inst.)		24,437,537	0	24,437,537	0.00	26.99	5.00
6.00	Total (sum of lines 3 thru 5)		127,048,208	-351,313	126,696,895	3,435,260.00	36.88	6.00
7.00	Total overhead cost (see instructions)		24,386,870	-351,313	24,035,557	1,023,390.00	23.49	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part IV Date/Time Prepared: 5/30/2017 10:19 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,558,208	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	13,873,168	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	332,817	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	63,476	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	167	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	289,428	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,964,004	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	5,145,066	17.00
18.00	Medicare Taxes - Employers Portion Only	1,203,282	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	188,909	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	162,571	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	24,781,096	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: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part V Date/Time Prepared: 5/30/2017 10:19 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	2,697,519	24,781,096	1.00
2.00	Hospital	2,697,519	24,781,096	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 5/30/2017 10:19 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)	0.130253	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	22,606,657	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	215,532,846	6.00
7.00	Medicaid cost (line 1 times line 6)	28,073,800	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)	5,467,143	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	731	9.00
10.00	Stand-alone CHIP charges	10,240	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	1,334	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	603	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	5,467,746	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)	3,322,413	1,242,507	4,564,920	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	432,754	161,840	594,594	21.00
22.00	Partial payment by patients approved for charity care	5,200	4,871	10,071	22.00
23.00	Cost of charity care (line 21 minus line 22)	427,554	156,969	584,523	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)	23,931,325	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	496,000	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	23,435,325	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	3,052,521	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,637,044	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,104,790	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/30/2017 10:19 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		4,611,498	4,611,498	1,629,253	6,240,751	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		12,607,893	12,607,893	2,515,596	15,123,489	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	321,550	518,788	840,338	15,939,405	16,779,743	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,350,826	68,512,249	76,863,075	-19,773,722	57,089,353	5.00
7.00	00700	OPERATION OF PLANT	1,642,527	6,998,596	8,641,123	-15,695	8,625,428	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	128,279	1,262,414	1,390,693	0	1,390,693	8.00
9.00	00900	HOUSEKEEPING	1,931,238	1,462,319	3,393,557	0	3,393,557	9.00
10.00	01000	DIETARY	2,020,940	1,098,636	3,119,576	-1,765,547	1,354,029	10.00
11.00	01100	CAFETERIA	0	0	0	1,758,227	1,758,227	11.00
13.00	01300	NURSING ADMINISTRATION	3,549,721	988,698	4,538,419	249,614	4,788,033	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	972,188	26,973,335	27,945,523	-26,381,197	1,564,326	14.00
15.00	01500	PHARMACY	2,704,036	18,371,473	21,075,509	-17,929,964	3,145,545	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	973,294	2,064,783	3,038,077	0	3,038,077	16.00
23.00	02300	ALLIED HEALTH	0	0	0	44,698	44,698	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,696,856	4,021,869	20,718,725	-817,969	19,900,756	30.00
31.00	03100	INTENSIVE CARE UNIT	5,739,777	3,280,580	9,020,357	-22,233	8,998,124	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	1,812,633	528,301	2,340,934	0	2,340,934	31.01
41.00	04100	SUBPROVIDER - IRF	961,252	342,536	1,303,788	-5,891	1,297,897	41.00
43.00	04300	NURSERY	0	70,089	70,089	373,063	443,152	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,675,162	6,050,496	12,725,658	3,111,908	15,837,566	50.00
51.00	05100	RECOVERY ROOM	2,305,864	376,683	2,682,547	-2,682,547	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,661,529	408,393	2,069,922	378,122	2,448,044	52.00
53.00	05300	ANESTHESIOLOGY	0	2,064,833	2,064,833	0	2,064,833	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,155,538	1,775,942	6,931,480	3,217,894	10,149,374	54.00
54.01	05401	ULTRASOUND	474,026	99,092	573,118	-573,118	0	54.01
56.00	05600	RADIOISOTOPE	432,640	893,052	1,325,692	-1,325,692	0	56.00
57.00	05700	CT SCAN	607,640	251,195	858,835	-858,835	0	57.00
58.00	05800	MRI	242,153	219,296	461,449	-461,449	0	58.00
60.00	06000	LABORATORY	5,510,583	6,840,215	12,350,798	-450,153	11,900,645	60.00
65.00	06500	RESPIRATORY THERAPY	1,790,610	507,864	2,298,474	-151,871	2,146,603	65.00
66.00	06600	PHYSICAL THERAPY	1,620,097	163,329	1,783,426	3,567	1,786,993	66.00
67.00	06700	OCCUPATIONAL THERAPY	583,189	44,521	627,710	-9,275	618,435	67.00
68.00	06800	SPEECH PATHOLOGY	360,632	25,050	385,682	0	385,682	68.00
69.00	06900	ELECTROCARDIOLOGY	4,771,968	2,676,183	7,448,151	318,137	7,766,288	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,341,475	2,341,475	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	23,255,069	23,255,069	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	110,675	367,824	478,499	17,642,361	18,120,860	73.00
74.00	07400	RENAL DIALYSIS	0	545,915	545,915	0	545,915	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	331,849	52,466	384,315	-384,315	0	76.01
76.03	03951	WOUND CARE	711,615	808,266	1,519,881	0	1,519,881	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	8,903,085	3,678,050	12,581,135	-147,653	12,433,482	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	90,053,972	181,562,722	271,616,694	-978,737	270,637,957	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,079	1,079	0	1,079	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	978,737	978,737	194.01
194.02	07952	SENIOR CIRCLE	53,073	26,672	79,745	0	79,745	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	0	0	0	0	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	90,107,045	181,590,473	271,697,518	0	271,697,518	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/30/2017 10:19 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	229,228	6,469,979		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-2,614,920	12,508,569		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-5,421	16,774,322		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-11,820,925	45,268,428		5.00
7.00	00700	OPERATION OF PLANT	0	8,625,428		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,390,693		8.00
9.00	00900	HOUSEKEEPING	0	3,393,557		9.00
10.00	01000	DIETARY	0	1,354,029		10.00
11.00	01100	CAFETERIA	-132,018	1,626,209		11.00
13.00	01300	NURSING ADMINISTRATION	-12,289	4,775,744		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,564,326		14.00
15.00	01500	PHARMACY	0	3,145,545		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,213	3,030,864		16.00
23.00	02300	ALLIED HEALTH	0	44,698		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-406,262	19,494,494		30.00
31.00	03100	INTENSIVE CARE UNIT	-1,607,104	7,391,020		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	-275,400	2,065,534		31.01
41.00	04100	SUBPROVIDER - IRF	0	1,297,897		41.00
43.00	04300	NURSERY	0	443,152		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-810,936	15,026,630		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,448,044		52.00
53.00	05300	ANESTHESIOLOGY	-1,859,316	205,517		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-85,656	10,063,718		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	11,900,645		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,146,603		65.00
66.00	06600	PHYSICAL THERAPY	0	1,786,993		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	618,435		67.00
68.00	06800	SPEECH PATHOLOGY	0	385,682		68.00
69.00	06900	ELECTROCARDIOLOGY	-411,150	7,355,138		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,341,475		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,255,069		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,515	18,118,345		73.00
74.00	07400	RENAL DIALYSIS	0	545,915		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	1,519,881		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-1,504,522	10,928,960		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-21,326,419	249,311,538		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,079		192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0		192.01
194.00	07950	NONREIMBURSABLE	0	0		194.00
194.01	07951	MARKETING	0	978,737		194.01
194.02	07952	SENIOR CIRCLE	0	79,745		194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	0		194.03
194.04	07954	VACANT UNFINISHED AREA	0	0		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-21,326,419	250,371,099		200.00

RECLASSIFICATIONS | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/30/2017 10:19 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	15,939,405		1.00
	0		0	15,939,405		
	B - OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	49,213		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	206		2.00
	0		0	49,419		
	C - RENTAL AND LEASE EXPENSES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,787		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,389,442		2.00
3.00	NURSING ADMINISTRATION	13.00	0	2,343		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
	0		0	2,393,572		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	169,576		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,457,890		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	126,154		3.00
	0		0	1,753,620		
	E - MARKETING DEPARTMENT					
1.00	MARKETING	194.01	351,313	627,424		1.00
	0		351,313	627,424		
	F - CHIEF NURSING OFFICER COST					
1.00	NURSING ADMINISTRATION	13.00	247,271	0		1.00
	0		247,271	0		
	G - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,292,262		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	23,255,069		2.00
3.00	OPERATING ROOM	50.00	0	839,200		3.00
	0		0	26,386,531		
	H - COST OF DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	17,648,101		1.00
	0		0	17,648,101		
	I - LABOR AND DELIVERY COSTS					
1.00	ADULTS & PEDIATRICS	30.00	0	9,741		1.00
2.00	NURSERY	43.00	371,317	1,746		2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	390,111	0		3.00
	0		761,428	11,487		
	K - RECOVERY ROOM					
1.00	OPERATING ROOM	50.00	2,305,864	376,683		1.00
	0		2,305,864	376,683		
	L - OTHER RADIOLOGY COST					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	1,756,459	1,462,635		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0		1,756,459	1,462,635		
	M - DIETARY COSTS TO CAFETERIA					
1.00	CAFETERIA	11.00	1,141,703	616,524		1.00
	0		1,141,703	616,524		
	N - REHAB THERAPY COSTS					
1.00	PHYSICAL THERAPY	66.00	0	3,583		1.00
	0		0	3,583		
	O - SLEEP LAB COSTS TO EKG					
1.00	ELECTROCARDIOLOGY	69.00	331,849	48,759		1.00
	0		331,849	48,759		

RECLASSIFICATIONS | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/30/2017 10:19 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	P - PARAMEDICAL EDUCATION					
1.00	ALLIED HEALTH	23.00	0	44,698		1.00
	0		0	44,698		
500.00	Grand Total: Increases		6,895,887	67,362,441		500.00

RECLASSIFICATIONS | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/30/2017 10:19 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	15,939,405	0		1.00
	0		0	15,939,405			
	B - OXYGEN COSTS						
1.00	RESPIRATORY THERAPY	65.00	0	49,419	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	49,419			
	C - RENTAL AND LEASE EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	854,689	10		1.00
2.00	OPERATION OF PLANT	7.00	0	15,695	10		2.00
3.00	DIETARY	10.00	0	7,320	0		3.00
4.00	SLEEP LAB	76.01	0	3,707	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	8,567	0		5.00
6.00	PHARMACY	15.00	0	281,863	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	66,282	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	22,233	0		8.00
9.00	SUBPROVIDER - IRF	41.00	0	2,308	0		9.00
10.00	OPERATING ROOM	50.00	0	409,839	0		10.00
11.00	LABORATORY	60.00	0	450,153	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	102,452	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	48,776	0		13.00
14.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,740	0		14.00
15.00	EMERGENCY	91.00	0	102,955	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	16	0		16.00
17.00	DELIVERY ROOM & LABOR ROOM	52.00	0	502	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	9,275	0		18.00
19.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,200	0		19.00
	0		0	2,393,572			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,753,620	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	1,753,620			
	E - MARKETING DEPARTMENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	351,313	627,424	0		1.00
	0		351,313	627,424			
	F - CHIEF NURSING OFFICER COST						
1.00	ADMINISTRATIVE & GENERAL	5.00	247,271	0	0		1.00
	0		247,271	0			
	G - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	26,372,836	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	13,695	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	26,386,531			
	H - COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	17,648,101	0		1.00
	0		0	17,648,101			
	I - LABOR AND DELIVERY COSTS						
1.00	ADULTS & PEDIATRICS	30.00	761,428		0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	11,487	0		2.00
3.00		0.00	0	0	0		3.00
	0		761,428	11,487			
	K - RECOVERY ROOM						
1.00	RECOVERY ROOM	51.00	2,305,864	376,683	0		1.00
	0		2,305,864	376,683			
	L - OTHER RADIOLOGY COST						
1.00	ULTRASOUND	54.01	474,026	99,092	0		1.00
2.00	RADIOISOTOPE	56.00	432,640	893,052	0		2.00
3.00	CT SCAN	57.00	607,640	251,195	0		3.00
4.00	MRI	58.00	242,153	219,296	0		4.00
	0		1,756,459	1,462,635			
	M - DIETARY COSTS TO CAFETERIA						
1.00	DIETARY	10.00	1,141,703	616,524	0		1.00
	0		1,141,703	616,524			
	N - REHAB THERAPY COSTS						
1.00	SUBPROVIDER - IRF	41.00	0	3,583	0		1.00
	0		0	3,583			
	O - SLEEP LAB COSTS TO EKG						
1.00	SLEEP LAB	76.01	331,849	48,759	0		1.00
	0		331,849	48,759			
	P - PARAMEDICAL EDUCATION						
1.00	EMERGENCY	91.00	0	44,698	0		1.00
	0		0	44,698			
500.00	Grand Total: Decreases		6,895,887	67,362,441			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2017 10:19 am

			Acquisitions				
		Beginning Balances	Purchases	Donation	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	2,949,373	0	0	0	0	1.00
2.00	Land Improvements	3,506,109	3,498	0	3,498	5,321	2.00
3.00	Buildings and Fixtures	165,888,425	800,471	0	800,471	0	3.00
4.00	Building Improvements	4,597,413	802,833	0	802,833	40,303	4.00
5.00	Fixed Equipment	6,602,865	144,133	0	144,133	21,660	5.00
6.00	Movable Equipment	66,452,306	6,077,180	0	6,077,180	1,519,933	6.00
7.00	HIT designated Assets	17,960,812	0	0	0	41,065	7.00
8.00	Subtotal (sum of lines 1-7)	267,957,303	7,828,115	0	7,828,115	1,628,282	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	267,957,303	7,828,115	0	7,828,115	1,628,282	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,949,373	0	1.00
2.00	Land Improvements	3,504,286	0	2.00
3.00	Buildings and Fixtures	166,688,896	0	3.00
4.00	Building Improvements	5,359,943	0	4.00
5.00	Fixed Equipment	6,725,338	0	5.00
6.00	Movable Equipment	71,009,553	0	6.00
7.00	HIT designated Assets	17,919,747	0	7.00
8.00	Subtotal (sum of lines 1-7)	274,157,136	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	274,157,136	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part II | Date/Time Prepared: 5/30/2017 10:19 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	4,611,498	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	12,431,625	164,737	0	0	11,531	2.00
3.00	Total (sum of lines 1-2)	17,043,123	164,737	0	0	11,531	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	4,611,498		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	12,607,893		2.00
3.00	Total (sum of lines 1-2)	0	17,219,391		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 5/30/2017 10:19 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	178,502,499	0	178,502,499	0.651096	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	95,654,638	0	95,654,638	0.348904	0	2.00
3.00	Total (sum of lines 1-2)	274,157,137	0	274,157,137	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,131,892	1,787	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	9,816,705	2,554,179	2.00
3.00	Total (sum of lines 1-2)	0	0	0	13,948,597	2,555,966	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	708,834	169,576	1,457,890	0	6,469,979	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	126,154	11,531	0	12,508,569	2.00
3.00	Total (sum of lines 1-2)	708,834	295,730	1,469,421	0	18,978,548	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/30/2017 10:19 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-113,524	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-81,686	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,960,323			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-23	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-4,868,934			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-132,018	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-2,515	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-7,213	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-628,826	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-3,093,663	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	TRAINING REVENUE	B	-12,289	NURSING ADMINISTRATION	13.00	0	33.00
33.01	MISC. NON PATIENT REVENUE	B	-145,729	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/30/2017 10:19 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	
33.02	NON-ALLOWABLE LEGAL FEES	A	-94,361	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PATIENT PHONES WAGE COSTS	A	-19,965	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PATIENT PHONES BENEFITS COSTS	A	-5,421	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	PATIENT TV DEPRECIATION	A	-87,421	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.05
33.06	MARKETING	A	-979,944	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PHYSICIAN RECRUITING	A	-148,335	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-8,482	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	CHARITABLE CONTRIBUTIONS	A	-121,094	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	COUNTRY CLUB DUES	A	-24,285	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	MINORITY INTEREST	A	-3,789,948	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	PATIENT PHONE DEPRECIATION	A	-295	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.12
33.14	PENALTIES	A	-125	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15			0		0.00	0	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-21,326,419				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: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2017 10:19 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	1.00	CAP REL COSTS-BLDG & FIXT	DIRECT ALLOCATION - CAPITAL	708,834	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	1,538,749	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS-BLDG & FI	103,480	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	45,740	0	4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	631,861	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HOME OFFICE COST	7,605,688	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	1,501,547	3,173,100	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	CIG LEASED EQUIPMENT	126,322	176,268	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	0	7,354,364	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	2,835,368	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	401K FEES	0	11,162	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	AUDIT FEES	0	104,824	4.08
4.14	5.00	ADMINISTRATIVE & GENERAL	PPSI FEES	0	29,300	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	CORPORATE OVERHEAD ALLOCATIO	0	2,448,482	4.15
4.17	5.00	ADMINISTRATIVE & GENERAL	PASI COLLECTION FEES	0	1,586,463	4.17
4.18	5.00	ADMINISTRATIVE & GENERAL	PASI LIEN UNIT COLLECTION FE	0	280,797	4.18
4.21	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICE CENTER ALLOCA	852,689	0	4.21
4.22	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS-MOVEABLE	16,284	0	4.22
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			13,131,194	18,000,128	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2017 10:19 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	708,834	11		1.00
2.00	1,538,749	0		2.00
3.00	103,480	9		3.00
4.00	45,740	9		4.00
4.01	631,861	9		4.01
4.02	7,605,688	0		4.02
4.03	-1,671,553	0		4.03
4.04	-49,946	10		4.04
4.05	-7,354,364	11		4.05
4.06	-2,835,368	0		4.06
4.07	-11,162	0		4.07
4.08	-104,824	0		4.08
4.14	-29,300	0		4.14
4.15	-2,448,482	0		4.15
4.17	-1,586,463	0		4.17
4.18	-280,797	0		4.18
4.21	852,689	0		4.21
4.22	16,284	9		4.22
5.00	-4,868,934			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	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2017 10:19 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	406,262	406,262	0	159,800	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	1,607,104	1,607,104	0	159,800	0	2.00
3.00	31.01	NEONATAL INTENSIVE CARE UNIT	275,400	275,400	0	159,800	0	3.00
4.00	50.00	OPERATING ROOM	810,936	810,936	0	159,800	0	4.00
5.00	53.00	ANESTHESIOLOGY	1,859,316	1,859,316	0	167,500	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	85,633	85,633	0	217,600	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	411,150	411,150	0	130,900	0	7.00
8.00	91.00	EMERGENCY	1,558,301	1,445,113	113,188	159,800	700	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			7,014,102	6,900,914	113,188		700	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	53,779	2,689	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			53,779	2,689	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	406,262		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	1,607,104		2.00
3.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	0	275,400		3.00
4.00	50.00	OPERATING ROOM	0	0	0	810,936		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	1,859,316		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	85,633		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	411,150		7.00
8.00	91.00	EMERGENCY	0	53,779	59,409	1,504,522		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	53,779	59,409	6,960,323		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/30/2017 10:19 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	6,469,979	6,469,979				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	12,508,569		12,508,569			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	16,774,322	20,489	41,688	16,836,499		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	45,268,428	282,947	575,705	1,453,693	47,580,773	5.00
7.00	00700	OPERATION OF PLANT	8,625,428	1,268,069	2,580,101	308,005	12,781,603	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,390,693	7,341	14,938	24,055	1,437,027	8.00
9.00	00900	HOUSEKEEPING	3,393,557	49,186	100,078	362,144	3,904,965	9.00
10.00	01000	DIETARY	1,354,029	149,748	304,688	164,874	1,973,339	10.00
11.00	01100	CAFETERIA	1,626,209	0	0	214,091	1,840,300	11.00
13.00	01300	NURSING ADMINISTRATION	4,775,744	72,900	148,329	712,008	5,708,981	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,564,326	104,040	211,688	182,304	2,062,358	14.00
15.00	01500	PHARMACY	3,145,545	57,073	116,125	507,058	3,825,801	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,030,864	19,659	40,000	182,511	3,273,034	16.00
23.00	02300	ALLIED HEALTH	44,698	0	0	0	44,698	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,494,494	858,939	1,747,662	2,988,208	25,089,303	30.00
31.00	03100	INTENSIVE CARE UNIT	7,391,020	149,663	304,517	1,076,317	8,921,517	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	2,065,534	57,856	117,719	339,903	2,581,012	31.01
41.00	04100	SUBPROVIDER - IRF	1,297,897	101,813	207,157	180,253	1,787,120	41.00
43.00	04300	NURSERY	443,152	18,346	37,328	69,629	568,455	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,026,630	503,122	1,023,691	1,684,113	18,237,556	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,448,044	100,139	203,751	384,721	3,136,655	52.00
53.00	05300	ANESTHESIOLOGY	205,517	8,685	17,672	0	231,874	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,063,718	362,774	738,127	1,296,131	12,460,750	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	11,900,645	135,956	276,626	1,033,339	13,346,566	60.00
65.00	06500	RESPIRATORY THERAPY	2,146,603	24,467	49,781	335,773	2,556,624	65.00
66.00	06600	PHYSICAL THERAPY	1,786,993	139,004	282,829	303,799	2,512,625	66.00
67.00	06700	OCCUPATIONAL THERAPY	618,435	0	0	109,359	727,794	67.00
68.00	06800	SPEECH PATHOLOGY	385,682	0	0	67,625	453,307	68.00
69.00	06900	ELECTROCARDIOLOGY	7,355,138	231,242	470,501	957,063	9,013,944	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,341,475	0	0	0	2,341,475	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,255,069	0	0	0	23,255,069	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,118,345	0	0	20,754	18,139,099	73.00
74.00	07400	RENAL DIALYSIS	545,915	5,053	10,281	0	561,249	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	1,519,881	79,919	162,610	133,441	1,895,851	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	10,928,960	351,055	714,283	1,669,498	13,663,796	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	249,311,538	5,159,485	10,497,875	16,760,669	245,914,520	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,395	15,047	0	22,442	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,079	978,484	1,990,897	0	2,970,460	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	978,737	2,335	4,750	65,878	1,051,700	194.01
194.02	07952	SENIOR CIRCLE	79,745	0	0	9,952	89,697	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	115,874	0	0	115,874	194.03
194.04	07954	VACANT UNFINISHED AREA	0	206,406	0	0	206,406	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	250,371,099	6,469,979	12,508,569	16,836,499	250,371,099	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/30/2017 10:19 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	47,580,773					5.00
7.00	00700	OPERATION OF PLANT	2,998,948	15,780,551				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	337,170	24,691	1,798,888			8.00
9.00	00900	HOUSEKEEPING	916,222	165,426	0	4,986,613		9.00
10.00	01000	DIETARY	463,005	503,638	0	161,089	3,101,071	10.00
11.00	01100	CAFETERIA	431,790	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,339,498	245,181	0	78,421	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	483,891	349,912	0	111,920	0	14.00
15.00	01500	PHARMACY	897,648	191,951	4,974	61,396	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	767,952	66,119	0	21,148	0	16.00
23.00	02300	ALLIED HEALTH	10,487	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,886,778	2,888,815	718,415	923,990	1,728,734	30.00
31.00	03100	INTENSIVE CARE UNIT	2,093,256	503,354	160,299	160,998	170,046	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	605,583	194,585	10,786	62,238	11,450	31.01
41.00	04100	SUBPROVIDER - IRF	419,312	342,422	69,768	109,524	99,450	41.00
43.00	04300	NURSERY	133,377	61,702	8,858	19,735	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,279,078	1,692,120	221,272	541,226	4,481	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	735,953	336,792	45,826	107,723	21,438	52.00
53.00	05300	ANESTHESIOLOGY	54,405	29,211	0	9,343	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,923,666	1,220,095	173,788	390,248	749	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	3,131,505	457,252	95	146,252	0	60.00
65.00	06500	RESPIRATORY THERAPY	599,861	82,287	0	26,319	0	65.00
66.00	06600	PHYSICAL THERAPY	589,537	467,505	7,028	149,532	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	170,762	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	106,359	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,114,942	777,720	68,434	248,754	24,446	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	549,380	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,456,337	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,255,977	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	131,686	16,995	0	5,436	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	444,824	268,788	8,611	85,972	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,205,936	1,180,682	300,734	377,642	69,678	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	46,535,125	12,067,243	1,798,888	3,798,906	2,130,472	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,266	24,872	0	7,955	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	696,959	3,290,872	0	1,052,591	410,555	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	7,852	0	2,511	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	246,760	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	21,046	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	27,188	389,712	0	124,650	560,044	194.03
194.04	07954	VACANT UNFINISHED AREA	48,429	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	47,580,773	15,780,551	1,798,888	4,986,613	3,101,071	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/30/2017 10:19 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,272,090					11.00
13.00	01300	NURSING ADMINISTRATION	88,950	7,461,031				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	59,714	0	3,067,795			14.00
15.00	01500	PHARMACY	54,320	339,211	0	5,375,301		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	41,245	0	0	0	4,169,498	16.00
23.00	02300	ALLIED HEALTH	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	533,737	1,999,040	0	0	322,232	30.00
31.00	03100	INTENSIVE CARE UNIT	161,894	720,032	0	0	78,389	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	44,737	227,388	0	0	43,366	31.01
41.00	04100	SUBPROVIDER - IRF	26,016	120,585	0	0	15,345	41.00
43.00	04300	NURSERY	10,903	46,580	0	0	6,143	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	264,832	1,126,634	0	0	799,980	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	60,257	257,370	0	0	33,942	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	39,296	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	194,254	867,082	0	0	553,780	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	213,208	0	214,019	0	457,902	60.00
65.00	06500	RESPIRATORY THERAPY	56,901	0	0	0	87,252	65.00
66.00	06600	PHYSICAL THERAPY	44,543	0	0	0	42,051	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,346	0	0	0	20,605	67.00
68.00	06800	SPEECH PATHOLOGY	7,624	0	0	0	7,341	68.00
69.00	06900	ELECTROCARDIOLOGY	149,517	640,253	0	0	332,038	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	257,319	0	101,575	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,596,457	0	395,667	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,785	0	0	5,375,301	386,427	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	7,200	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	20,079	0	0	0	21,299	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	210,957	1,116,856	0	0	417,668	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,260,819	7,461,031	3,067,795	5,375,301	4,169,498	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	9,312	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	1,959	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	0	0	0	0	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,272,090	7,461,031	3,067,795	5,375,301	4,169,498	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/30/2017 10:19 am

		Cost Center Description	ALLIED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
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
23.00	02300	ALLIED HEALTH	55,185					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	40,091,044	0	40,091,044		30.00
31.00	03100	INTENSIVE CARE UNIT	0	12,969,785	0	12,969,785		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	3,781,145	0	3,781,145		31.01
41.00	04100	SUBPROVIDER - IRF	0	2,989,542	0	2,989,542		41.00
43.00	04300	NURSERY	0	855,753	0	855,753		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	27,167,179	0	27,167,179		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,735,956	0	4,735,956		52.00
53.00	05300	ANESTHESIOLOGY	0	364,129	0	364,129		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,784,412	0	18,784,412		54.00
54.01	05401	ULTRASOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	0	17,966,799	0	17,966,799		60.00
65.00	06500	RESPIRATORY THERAPY	0	3,409,244	0	3,409,244		65.00
66.00	06600	PHYSICAL THERAPY	0	3,812,821	0	3,812,821		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	934,507	0	934,507		67.00
68.00	06800	SPEECH PATHOLOGY	0	574,631	0	574,631		68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,370,048	0	13,370,048		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,249,749	0	3,249,749		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	31,703,530	0	31,703,530		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	28,158,589	0	28,158,589		73.00
74.00	07400	RENAL DIALYSIS	0	722,566	0	722,566		74.00
76.00	03950	ANCILLARY	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0	0		76.01
76.03	03951	WOUND CARE	0	2,745,424	0	2,745,424		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	55,185	20,599,134	0	20,599,134		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	55,185	238,985,987	0	238,985,987		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	60,535	0	60,535		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8,421,437	0	8,421,437		192.00
192.01	19201	OTHER NONREIMBURSABLE	0	10,363	0	10,363		192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0		194.00
194.01	07951	MARKETING	0	1,307,772	0	1,307,772		194.01
194.02	07952	SENIOR CIRCLE	0	112,702	0	112,702		194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	1,217,468	0	1,217,468		194.03
194.04	07954	VACANT UNFINISHED AREA	0	254,835	0	254,835		194.04
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	55,185	250,371,099	0	250,371,099		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/30/2017 10:19 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	20,489	41,688	62,177	62,177	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	282,947	575,705	858,652	5,372	5.00
7.00	00700	OPERATION OF PLANT	0	1,268,069	2,580,101	3,848,170	1,138	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,341	14,938	22,279	89	8.00
9.00	00900	HOUSEKEEPING	0	49,186	100,078	149,264	1,338	9.00
10.00	01000	DIETARY	0	149,748	304,688	454,436	609	10.00
11.00	01100	CAFETERIA	0	0	0	0	791	11.00
13.00	01300	NURSING ADMINISTRATION	0	72,900	148,329	221,229	2,631	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	104,040	211,688	315,728	674	14.00
15.00	01500	PHARMACY	0	57,073	116,125	173,198	1,874	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,659	40,000	59,659	674	16.00
23.00	02300	ALLIED HEALTH	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	858,939	1,747,662	2,606,601	11,000	30.00
31.00	03100	INTENSIVE CARE UNIT	0	149,663	304,517	454,180	3,978	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	57,856	117,719	175,575	1,256	31.01
41.00	04100	SUBPROVIDER - IRF	0	101,813	207,157	308,970	666	41.00
43.00	04300	NURSERY	0	18,346	37,328	55,674	257	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	503,122	1,023,691	1,526,813	6,224	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	100,139	203,751	303,890	1,422	52.00
53.00	05300	ANESTHESIOLOGY	0	8,685	17,672	26,357	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	362,774	738,127	1,100,901	4,790	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	135,956	276,626	412,582	3,819	60.00
65.00	06500	RESPIRATORY THERAPY	0	24,467	49,781	74,248	1,241	65.00
66.00	06600	PHYSICAL THERAPY	0	139,004	282,829	421,833	1,123	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	404	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	250	68.00
69.00	06900	ELECTROCARDIOLOGY	0	231,242	470,501	701,743	3,537	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	77	73.00
74.00	07400	RENAL DIALYSIS	0	5,053	10,281	15,334	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	79,919	162,610	242,529	493	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	351,055	714,283	1,065,338	6,170	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	5,159,485	10,497,875	15,657,360	61,897	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,395	15,047	22,442	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	978,484	1,990,897	2,969,381	0	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	2,335	4,750	7,085	243	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	37	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	115,874	0	115,874	0	194.03
194.04	07954	VACANT UNFINISHED AREA	0	206,406	0	206,406	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	6,469,979	12,508,569	18,978,548	62,177	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/30/2017 10:19 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	864,024					5.00
7.00	00700	OPERATION OF PLANT	54,462	3,903,770				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,123	6,108	34,599			8.00
9.00	00900	HOUSEKEEPING	16,639	40,923	0	208,164		9.00
10.00	01000	DIETARY	8,408	124,589	0	6,725	594,767	10.00
11.00	01100	CAFETERIA	7,842	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	24,326	60,653	0	3,274	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,788	86,561	0	4,672	0	14.00
15.00	01500	PHARMACY	16,302	47,484	96	2,563	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,946	16,356	0	883	0	16.00
23.00	02300	ALLIED HEALTH	190	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	106,842	714,631	13,818	38,572	331,560	30.00
31.00	03100	INTENSIVE CARE UNIT	38,015	124,519	3,083	6,721	32,614	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	10,998	48,136	207	2,598	2,196	31.01
41.00	04100	SUBPROVIDER - IRF	7,615	84,708	1,342	4,572	19,074	41.00
43.00	04300	NURSERY	2,422	15,264	170	824	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	77,710	418,594	4,256	22,593	859	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,365	83,315	881	4,497	4,112	52.00
53.00	05300	ANESTHESIOLOGY	988	7,226	0	390	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,095	301,825	3,343	16,291	144	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	56,870	113,114	2	6,105	0	60.00
65.00	06500	RESPIRATORY THERAPY	10,894	20,356	0	1,099	0	65.00
66.00	06600	PHYSICAL THERAPY	10,706	115,651	135	6,242	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,101	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,932	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	38,408	192,391	1,316	10,384	4,689	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,977	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	99,090	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,291	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,391	4,204	0	227	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	8,078	66,492	166	3,589	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	58,221	292,075	5,784	15,765	13,364	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	845,035	2,985,175	34,599	158,586	408,612	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	96	6,153	0	332	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,657	814,093	0	43,938	78,742	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	1,942	0	105	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	4,481	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	382	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	494	96,407	0	5,203	107,413	194.03
194.04	07954	VACANT UNFINISHED AREA	879	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	864,024	3,903,770	34,599	208,164	594,767	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/30/2017 10:19 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	8,633					11.00
13.00	01300	NURSING ADMINISTRATION	338	312,451				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	227	0	416,650			14.00
15.00	01500	PHARMACY	206	14,204	0	255,927		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	157	0	0	0	91,675	16.00
23.00	02300	ALLIED HEALTH	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,030	83,733	0	0	7,091	30.00
31.00	03100	INTENSIVE CARE UNIT	615	30,151	0	0	1,725	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	170	9,522	0	0	954	31.01
41.00	04100	SUBPROVIDER - IRF	99	5,049	0	0	338	41.00
43.00	04300	NURSERY	41	1,951	0	0	135	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,006	47,177	0	0	17,524	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	229	10,777	0	0	747	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	865	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	738	36,309	0	0	12,187	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	810	0	29,066	0	10,077	60.00
65.00	06500	RESPIRATORY THERAPY	216	0	0	0	1,920	65.00
66.00	06600	PHYSICAL THERAPY	169	0	0	0	925	66.00
67.00	06700	OCCUPATIONAL THERAPY	58	0	0	0	453	67.00
68.00	06800	SPEECH PATHOLOGY	29	0	0	0	162	68.00
69.00	06900	ELECTROCARDIOLOGY	568	26,810	0	0	7,307	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	34,947	0	2,235	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	352,637	0	8,707	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7	0	0	255,927	8,504	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	158	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	76	0	0	0	469	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	802	46,768	0	0	9,192	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,591	312,451	416,650	255,927	91,675	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	35	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	7	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	0	0	0	0	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8,633	312,451	416,650	255,927	91,675	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/30/2017 10:19 am

		Cost Center Description	ALLIED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
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
23.00	02300	ALLIED HEALTH	190					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		3,915,878	0	3,915,878		30.00
31.00	03100	INTENSIVE CARE UNIT		695,601	0	695,601		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		251,612	0	251,612		31.01
41.00	04100	SUBPROVIDER - IRF		432,433	0	432,433		41.00
43.00	04300	NURSERY		76,738	0	76,738		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		2,122,756	0	2,122,756		50.00
51.00	05100	RECOVERY ROOM		0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		423,235	0	423,235		52.00
53.00	05300	ANESTHESIOLOGY		35,826	0	35,826		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		1,529,623	0	1,529,623		54.00
54.01	05401	ULTRASOUND		0	0	0		54.01
56.00	05600	RADIOISOTOPE		0	0	0		56.00
57.00	05700	CT SCAN		0	0	0		57.00
58.00	05800	MRI		0	0	0		58.00
60.00	06000	LABORATORY		632,445	0	632,445		60.00
65.00	06500	RESPIRATORY THERAPY		109,974	0	109,974		65.00
66.00	06600	PHYSICAL THERAPY		556,784	0	556,784		66.00
67.00	06700	OCCUPATIONAL THERAPY		4,016	0	4,016		67.00
68.00	06800	SPEECH PATHOLOGY		2,373	0	2,373		68.00
69.00	06900	ELECTROCARDIOLOGY		987,153	0	987,153		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		47,159	0	47,159		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		460,434	0	460,434		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		341,806	0	341,806		73.00
74.00	07400	RENAL DIALYSIS		22,314	0	22,314		74.00
76.00	03950	ANCILLARY		0	0	0		76.00
76.01	03610	SLEEP LAB		0	0	0		76.01
76.03	03951	WOUND CARE		321,892	0	321,892		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC		0	0	0		90.00
91.00	09100	EMERGENCY		1,513,479	0	1,513,479		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	14,483,531	0	14,483,531		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		29,023	0	29,023		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		3,918,811	0	3,918,811		192.00
192.01	19201	OTHER NONREIMBURSABLE		2,047	0	2,047		192.01
194.00	07950	NONREIMBURSABLE		0	0	0		194.00
194.01	07951	MARKETING		11,844	0	11,844		194.01
194.02	07952	SENIOR CIRCLE		426	0	426		194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA		325,391	0	325,391		194.03
194.04	07954	VACANT UNFINISHED AREA		207,285	0	207,285		194.04
200.00		Cross Foot Adjustments	190	190	0	190		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	190	18,978,548	0	18,978,548		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/30/2017 10:19 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	842,513					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		800,546				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,668	2,668	89,785,495			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	36,845	36,845	7,752,242	-47,580,773	202,790,326	5.00
7.00	00700	OPERATION OF PLANT	165,126	165,126	1,642,527	0	12,781,603	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	956	956	128,279	0	1,437,027	8.00
9.00	00900	HOUSEKEEPING	6,405	6,405	1,931,238	0	3,904,965	9.00
10.00	01000	DIETARY	19,500	19,500	879,237	0	1,973,339	10.00
11.00	01100	CAFETERIA	0	0	1,141,703	0	1,840,300	11.00
13.00	01300	NURSING ADMINISTRATION	9,493	9,493	3,796,992	0	5,708,981	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,548	13,548	972,188	0	2,062,358	14.00
15.00	01500	PHARMACY	7,432	7,432	2,704,036	0	3,825,801	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,560	2,560	973,294	0	3,273,034	16.00
23.00	02300	ALLIED HEALTH	0	0	0	0	44,698	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	111,850	111,850	15,935,428	0	25,089,303	30.00
31.00	03100	INTENSIVE CARE UNIT	19,489	19,489	5,739,777	0	8,921,517	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	7,534	7,534	1,812,633	0	2,581,012	31.01
41.00	04100	SUBPROVIDER - IRF	13,258	13,258	961,252	0	1,787,120	41.00
43.00	04300	NURSERY	2,389	2,389	371,317	0	568,455	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	65,516	65,516	8,981,026	0	18,237,556	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,040	13,040	2,051,640	0	3,136,655	52.00
53.00	05300	ANESTHESIOLOGY	1,131	1,131	0	0	231,874	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,240	47,240	6,911,997	0	12,460,750	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	17,704	17,704	5,510,583	0	13,346,566	60.00
65.00	06500	RESPIRATORY THERAPY	3,186	3,186	1,790,610	0	2,556,624	65.00
66.00	06600	PHYSICAL THERAPY	18,101	18,101	1,620,097	0	2,512,625	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	583,189	0	727,794	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	360,632	0	453,307	68.00
69.00	06900	ELECTROCARDIOLOGY	30,112	30,112	5,103,817	0	9,013,944	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,341,475	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	23,255,069	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	110,675	0	18,139,099	73.00
74.00	07400	RENAL DIALYSIS	658	658	0	0	561,249	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	10,407	10,407	711,615	0	1,895,851	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	45,714	45,714	8,903,085	0	13,663,796	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	671,862	671,862	89,381,109	-47,580,773	198,333,747	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	963	963	0	0	22,442	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	127,417	127,417	0	0	2,970,460	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	304	304	351,313	0	1,051,700	194.01
194.02	07952	SENIOR CIRCLE	0	0	53,073	0	89,697	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	15,089	0	0	0	115,874	194.03
194.04	07954	VACANT UNFINISHED AREA	26,878	0	0	0	206,406	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,469,979	12,508,569	16,836,499		47,580,773	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.679382	15.625047	0.187519		0.234630	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			62,177		864,024	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000693		0.004261	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/30/2017 10:19 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			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	610,996					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	956	2,163,042				8.00
9.00	00900	HOUSEKEEPING	6,405	0	603,635			9.00
10.00	01000	DIETARY	19,500	0	19,500	256,754		10.00
11.00	01100	CAFETERIA	0	0	0	0	117,117	11.00
13.00	01300	NURSING ADMINISTRATION	9,493	0	9,493	0	4,585	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,548	0	13,548	0	3,078	14.00
15.00	01500	PHARMACY	7,432	5,981	7,432	0	2,800	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,560	0	2,560	0	2,126	16.00
23.00	02300	ALLIED HEALTH	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	111,850	863,846	111,850	143,131	27,512	30.00
31.00	03100	INTENSIVE CARE UNIT	19,489	192,749	19,489	14,079	8,345	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	7,534	12,970	7,534	948	2,306	31.01
41.00	04100	SUBPROVIDER - IRF	13,258	83,891	13,258	8,234	1,341	41.00
43.00	04300	NURSERY	2,389	10,651	2,389	0	562	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	65,516	266,065	65,516	371	13,651	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,040	55,103	13,040	1,775	3,106	52.00
53.00	05300	ANESTHESIOLOGY	1,131	0	1,131	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,240	208,968	47,240	62	10,013	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	17,704	114	17,704	0	10,990	60.00
65.00	06500	RESPIRATORY THERAPY	3,186	0	3,186	0	2,933	65.00
66.00	06600	PHYSICAL THERAPY	18,101	8,451	18,101	0	2,296	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	791	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	393	68.00
69.00	06900	ELECTROCARDIOLOGY	30,112	82,287	30,112	2,024	7,707	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	92	73.00
74.00	07400	RENAL DIALYSIS	658	0	658	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	10,407	10,354	10,407	0	1,035	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	45,714	361,612	45,714	5,769	10,874	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	467,223	2,163,042	459,862	176,393	116,536	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	963	0	963	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	127,417	0	127,417	33,992	0	192.00
192.01	19201	OTHER NONREIMBURSABLE	304	0	304	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	480	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	101	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	15,089	0	15,089	46,369	0	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	15,780,551	1,798,888	4,986,613	3,101,071	2,272,090	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.827585	0.831647	8.260974	12.077985	19.400172	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,903,770	34,599	208,164	594,767	8,633	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.389191	0.015996	0.344851	2.316486	0.073713	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/30/2017 10:19 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	ALLIED HEALTH (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	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
13.00	01300	NURSING ADMINISTRATION	59,476,007					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	27,809,785				14.00
15.00	01500	PHARMACY	2,704,036	0	18,347,639			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,834,785,600		16.00
23.00	02300	ALLIED HEALTH	0	0	0	0	100	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,935,427	0	0	141,827,517	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,739,777	0	0	34,502,369	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	1,812,633	0	0	19,087,125	0	31.01
41.00	04100	SUBPROVIDER - IRF	961,252	0	0	6,753,755	0	41.00
43.00	04300	NURSERY	371,317	0	0	2,703,787	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,981,026	0	0	351,722,888	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,051,640	0	0	14,939,230	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	17,295,644	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,911,997	0	0	243,741,329	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,940,088	0	201,541,214	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	38,403,163	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	18,508,149	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	9,069,281	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,231,203	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,103,817	0	0	146,143,379	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,332,605	0	44,707,386	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,537,092	0	174,149,214	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	18,347,639	170,082,197	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,169,215	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	9,374,649	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	8,903,085	0	0	183,832,906	100	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	59,476,007	27,809,785	18,347,639	1,834,785,600	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	0	0	0	0	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,461,031	3,067,795	5,375,301	4,169,498	55,185	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.125446	0.110314	0.292970	0.002272	551.850000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	312,451	416,650	255,927	91,675	190	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.005253	0.014982	0.013949	0.000050	1.900000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 10:19 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	40,091,044		40,091,044	0	40,091,044	30.00
31.00	03100	INTENSIVE CARE UNIT	12,969,785		12,969,785	0	12,969,785	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	3,781,145		3,781,145	0	3,781,145	31.01
41.00	04100	SUBPROVIDER - IRF	2,989,542		2,989,542	0	2,989,542	41.00
43.00	04300	NURSERY	855,753		855,753	0	855,753	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,167,179		27,167,179	0	27,167,179	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,735,956		4,735,956	0	4,735,956	52.00
53.00	05300	ANESTHESIOLOGY	364,129		364,129	0	364,129	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,784,412		18,784,412	0	18,784,412	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	17,966,799		17,966,799	0	17,966,799	60.00
65.00	06500	RESPIRATORY THERAPY	3,409,244	0	3,409,244	0	3,409,244	65.00
66.00	06600	PHYSICAL THERAPY	3,812,821	0	3,812,821	0	3,812,821	66.00
67.00	06700	OCCUPATIONAL THERAPY	934,507	0	934,507	0	934,507	67.00
68.00	06800	SPEECH PATHOLOGY	574,631	0	574,631	0	574,631	68.00
69.00	06900	ELECTROCARDIOLOGY	13,370,048		13,370,048	0	13,370,048	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,249,749		3,249,749	0	3,249,749	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,703,530		31,703,530	0	31,703,530	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,158,589		28,158,589	0	28,158,589	73.00
74.00	07400	RENAL DIALYSIS	722,566		722,566	0	722,566	74.00
76.00	03950	ANCILLARY	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03951	WOUND CARE	2,745,424		2,745,424	0	2,745,424	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	20,599,134		20,599,134	59,409	20,658,543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,186,113		3,186,113		3,186,113	92.00
200.00		Subtotal (see instructions)	242,172,100	0	242,172,100	59,409	242,231,509	200.00
201.00		Less Observation Beds	3,186,113		3,186,113		3,186,113	201.00
202.00		Total (see instructions)	238,985,987	0	238,985,987	59,409	239,045,396	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 10:19 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	130,834,685		130,834,685			30.00
31.00	03100	INTENSIVE CARE UNIT	34,502,369		34,502,369			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	19,087,125		19,087,125			31.01
41.00	04100	SUBPROVIDER - IRF	6,753,755		6,753,755			41.00
43.00	04300	NURSERY	2,703,787		2,703,787			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	160,731,323	190,991,565	351,722,888	0.077240	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,250,083	689,147	14,939,230	0.317015	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	8,221,907	9,073,737	17,295,644	0.021053	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,470,284	192,271,045	243,741,329	0.077067	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	78,224,489	123,316,725	201,541,214	0.089147	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	35,567,369	2,835,794	38,403,163	0.088775	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	12,948,323	5,559,826	18,508,149	0.206008	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,113,301	955,980	9,069,281	0.103041	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,357,796	873,407	3,231,203	0.177838	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	52,412,461	93,730,918	146,143,379	0.091486	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,295,513	19,411,873	44,707,386	0.072689	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	110,591,908	63,557,306	174,149,214	0.182048	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,108,917	108,973,280	170,082,197	0.165559	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,086,235	82,980	3,169,215	0.227995	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03951	WOUND CARE	429,294	8,945,355	9,374,649	0.292856	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	54,099,352	129,733,554	183,832,906	0.112054	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,748,722	7,244,110	10,992,832	0.289836	0.000000	92.00
200.00		Subtotal (see instructions)	876,538,998	958,246,602	1,834,785,600			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	876,538,998	958,246,602	1,834,785,600			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 10:19 am

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		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
31.01	03101	NEONATAL INTENSIVE CARE UNIT	
41.00	04100	SUBPROVIDER - IRF	
43.00	04300	NURSERY	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.077240
51.00	05100	RECOVERY ROOM	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.317015
53.00	05300	ANESTHESIOLOGY	0.021053
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.077067
54.01	05401	ULTRASOUND	0.000000
56.00	05600	RADIOISOTOPE	0.000000
57.00	05700	CT SCAN	0.000000
58.00	05800	MRI	0.000000
60.00	06000	LABORATORY	0.089147
65.00	06500	RESPIRATORY THERAPY	0.088775
66.00	06600	PHYSICAL THERAPY	0.206008
67.00	06700	OCCUPATIONAL THERAPY	0.103041
68.00	06800	SPEECH PATHOLOGY	0.177838
69.00	06900	ELECTROCARDIOLOGY	0.091486
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.072689
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.182048
73.00	07300	DRUGS CHARGED TO PATIENTS	0.165559
74.00	07400	RENAL DIALYSIS	0.227995
76.00	03950	ANCILLARY	0.000000
76.01	03610	SLEEP LAB	0.000000
76.03	03951	WOUND CARE	0.292856
		OUTPATIENT SERVICE COST CENTERS	
90.00	09000	CLINIC	0.000000
91.00	09100	EMERGENCY	0.112377
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.289836
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 10:19 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	40,091,044		40,091,044	0	40,091,044	30.00
31.00	03100	INTENSIVE CARE UNIT	12,969,785		12,969,785	0	12,969,785	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	3,781,145		3,781,145	0	3,781,145	31.01
41.00	04100	SUBPROVIDER - IRF	2,989,542		2,989,542	0	2,989,542	41.00
43.00	04300	NURSERY	855,753		855,753	0	855,753	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,167,179		27,167,179	0	27,167,179	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,735,956		4,735,956	0	4,735,956	52.00
53.00	05300	ANESTHESIOLOGY	364,129		364,129	0	364,129	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,784,412		18,784,412	0	18,784,412	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	17,966,799		17,966,799	0	17,966,799	60.00
65.00	06500	RESPIRATORY THERAPY	3,409,244	0	3,409,244	0	3,409,244	65.00
66.00	06600	PHYSICAL THERAPY	3,812,821	0	3,812,821	0	3,812,821	66.00
67.00	06700	OCCUPATIONAL THERAPY	934,507	0	934,507	0	934,507	67.00
68.00	06800	SPEECH PATHOLOGY	574,631	0	574,631	0	574,631	68.00
69.00	06900	ELECTROCARDIOLOGY	13,370,048		13,370,048	0	13,370,048	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,249,749		3,249,749	0	3,249,749	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,703,530		31,703,530	0	31,703,530	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,158,589		28,158,589	0	28,158,589	73.00
74.00	07400	RENAL DIALYSIS	722,566		722,566	0	722,566	74.00
76.00	03950	ANCILLARY	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03951	WOUND CARE	2,745,424		2,745,424	0	2,745,424	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	20,599,134		20,599,134	59,409	20,658,543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,186,113		3,186,113		3,186,113	92.00
200.00		Subtotal (see instructions)	242,172,100	0	242,172,100	59,409	242,231,509	200.00
201.00		Less Observation Beds	3,186,113		3,186,113		3,186,113	201.00
202.00		Total (see instructions)	238,985,987	0	238,985,987	59,409	239,045,396	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 10:19 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	130,834,685		130,834,685			30.00
31.00	03100	INTENSIVE CARE UNIT	34,502,369		34,502,369			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	19,087,125		19,087,125			31.01
41.00	04100	SUBPROVIDER - IRF	6,753,755		6,753,755			41.00
43.00	04300	NURSERY	2,703,787		2,703,787			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	160,731,323	190,991,565	351,722,888	0.077240	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,250,083	689,147	14,939,230	0.317015	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	8,221,907	9,073,737	17,295,644	0.021053	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,470,284	192,271,045	243,741,329	0.077067	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	78,224,489	123,316,725	201,541,214	0.089147	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	35,567,369	2,835,794	38,403,163	0.088775	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	12,948,323	5,559,826	18,508,149	0.206008	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,113,301	955,980	9,069,281	0.103041	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,357,796	873,407	3,231,203	0.177838	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	52,412,461	93,730,918	146,143,379	0.091486	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,295,513	19,411,873	44,707,386	0.072689	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	110,591,908	63,557,306	174,149,214	0.182048	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,108,917	108,973,280	170,082,197	0.165559	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,086,235	82,980	3,169,215	0.227995	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03951	WOUND CARE	429,294	8,945,355	9,374,649	0.292856	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	54,099,352	129,733,554	183,832,906	0.112054	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,748,722	7,244,110	10,992,832	0.289836	0.000000	92.00
200.00		Subtotal (see instructions)	876,538,998	958,246,602	1,834,785,600			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	876,538,998	958,246,602	1,834,785,600			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/30/2017 10:19 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT			31.01
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03950	ANCILLARY	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
76.03	03951	WOUND CARE	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part I | Date/Time Prepared: 5/30/2017 10:19 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	3,915,878	0	3,915,878	50,559	77.45	30.00
31.00	INTENSIVE CARE UNIT	695,601		695,601	6,917	100.56	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	251,612		251,612	2,388	105.37	31.01
41.00	SUBPROVIDER - IRF	432,433	0	432,433	2,607	165.87	41.00
43.00	NURSERY	76,738		76,738	1,001	76.66	43.00
200.00	Total (lines 30-199)	5,372,262		5,372,262	63,472		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	23,301	1,804,662	30.00
31.00	INTENSIVE CARE UNIT	3,650	367,044	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	0	0	31.01
41.00	SUBPROVIDER - IRF	1,719	285,131	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	28,670	2,456,837	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/30/2017 10:19 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	2,122,756	351,722,888	0.006035	69,377,162	418,691	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	423,235	14,939,230	0.028330	36,662	1,039	52.00
53.00	05300	ANESTHESIOLOGY	35,826	17,295,644	0.002071	2,841,664	5,885	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,529,623	243,741,329	0.006276	26,061,814	163,564	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	632,445	201,541,214	0.003138	37,161,185	116,612	60.00
65.00	06500	RESPIRATORY THERAPY	109,974	38,403,163	0.002864	20,508,013	58,735	65.00
66.00	06600	PHYSICAL THERAPY	556,784	18,508,149	0.030083	5,937,012	178,603	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,016	9,069,281	0.000443	3,482,090	1,543	67.00
68.00	06800	SPEECH PATHOLOGY	2,373	3,231,203	0.000734	1,226,323	900	68.00
69.00	06900	ELECTROCARDIOLOGY	987,153	146,143,379	0.006755	22,996,682	155,343	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,159	44,707,386	0.001055	11,534,510	12,169	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	460,434	174,149,214	0.002644	49,040,118	129,662	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	341,806	170,082,197	0.002010	27,704,811	55,687	73.00
74.00	07400	RENAL DIALYSIS	22,314	3,169,215	0.007041	1,921,116	13,527	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03951	WOUND CARE	321,892	9,374,649	0.034336	215,015	7,383	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1,513,479	183,832,906	0.008233	25,604,175	210,799	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	311,204	10,992,832	0.028310	1,670,950	47,305	92.00
200.00		Total (lines 50-199)	9,422,473	1,640,903,879		307,319,302	1,577,447	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 5/30/2017 10:19 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	0	0		0	31.01
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	50,559	0.00	23,301	0		30.00
31.00	03100	INTENSIVE CARE UNIT	6,917	0.00	3,650	0		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	2,388	0.00	0	0		31.01
41.00	04100	SUBPROVIDER - IRF	2,607	0.00	1,719	0		41.00
43.00	04300	NURSERY	1,001	0.00	0	0		43.00
200.00		Total (lines 30-199)	63,472		28,670	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/30/2017 10:19 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	55,185	0	55,185	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	55,185	0	55,185	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/30/2017 10:19 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	351,722,888	0.000000	0.000000	69,377,162	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	14,939,230	0.000000	0.000000	36,662	52.00
53.00	05300	ANESTHESIOLOGY	0	17,295,644	0.000000	0.000000	2,841,664	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	243,741,329	0.000000	0.000000	26,061,814	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	201,541,214	0.000000	0.000000	37,161,185	60.00
65.00	06500	RESPIRATORY THERAPY	0	38,403,163	0.000000	0.000000	20,508,013	65.00
66.00	06600	PHYSICAL THERAPY	0	18,508,149	0.000000	0.000000	5,937,012	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,069,281	0.000000	0.000000	3,482,090	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,231,203	0.000000	0.000000	1,226,323	68.00
69.00	06900	ELECTROCARDIOLOGY	0	146,143,379	0.000000	0.000000	22,996,682	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	44,707,386	0.000000	0.000000	11,534,510	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	174,149,214	0.000000	0.000000	49,040,118	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	170,082,197	0.000000	0.000000	27,704,811	73.00
74.00	07400	RENAL DIALYSIS	0	3,169,215	0.000000	0.000000	1,921,116	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.03	03951	WOUND CARE	0	9,374,649	0.000000	0.000000	215,015	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	55,185	183,832,906	0.000300	0.000300	25,604,175	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	10,992,832	0.000000	0.000000	1,670,950	92.00
200.00		Total (lines 50-199)	55,185	1,640,903,879			307,319,302	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/30/2017 10:19 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	58,292,614	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	559	0		52.00
53.00	05300	ANESTHESIOLOGY	0	2,045,155	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	59,438,404	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	13,328,384	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	852,010	0		65.00
66.00	06600	PHYSICAL THERAPY	0	162,438	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	37,865,442	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,037,090	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	26,223,311	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,695,748	0		73.00
74.00	07400	RENAL DIALYSIS	0	77,544	0		74.00
76.00	03950	ANCILLARY	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
76.03	03951	WOUND CARE	0	3,417,222	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	7,681	24,708,690	7,413		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,296,951	0		92.00
200.00		Total (lines 50-199)	7,681	269,441,562	7,413		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/30/2017 10:19 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	0.077240	58,292,614	0	0	4,502,522	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.317015	559	0	0	177	52.00
53.00	05300	ANESTHESIOLOGY	0.021053	2,045,155	0	0	43,057	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.077067	59,438,404	0	0	4,580,739	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.089147	13,328,384	29,622	0	1,188,185	60.00
65.00	06500	RESPIRATORY THERAPY	0.088775	852,010	0	0	75,637	65.00
66.00	06600	PHYSICAL THERAPY	0.206008	162,438	0	0	33,464	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.103041	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.177838	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.091486	37,865,442	0	0	3,464,158	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.072689	6,037,090	0	0	438,830	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.182048	26,223,311	0	0	4,773,901	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.165559	34,695,748	0	423,507	5,744,193	73.00
74.00	07400	RENAL DIALYSIS	0.227995	77,544	0	0	17,680	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.292856	3,417,222	0	0	1,000,754	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.112054	24,708,690	78	0	2,768,708	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.289836	2,296,951	0	0	665,739	92.00
200.00		Subtotal (see instructions)		269,441,562	29,700	423,507	29,297,744	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		269,441,562	29,700	423,507	29,297,744	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/30/2017 10:19 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	2,641	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
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	70,115		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	9	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	2,650	70,115		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	2,650	70,115		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/30/2017 10:19 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,122,756	351,722,888	0.006035	29,505	178	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	423,235	14,939,230	0.028330	0	0	52.00
53.00	05300	ANESTHESIOLOGY	35,826	17,295,644	0.002071	769	2	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,529,623	243,741,329	0.006276	168,203	1,056	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	632,445	201,541,214	0.003138	642,192	2,015	60.00
65.00	06500	RESPIRATORY THERAPY	109,974	38,403,163	0.002864	684	2	65.00
66.00	06600	PHYSICAL THERAPY	556,784	18,508,149	0.030083	1,590,284	47,841	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,016	9,069,281	0.000443	1,558,434	690	67.00
68.00	06800	SPEECH PATHOLOGY	2,373	3,231,203	0.000734	345,690	254	68.00
69.00	06900	ELECTROCARDIOLOGY	987,153	146,143,379	0.006755	54,620	369	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,159	44,707,386	0.001055	17,396	18	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	460,434	174,149,214	0.002644	4,474	12	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	341,806	170,082,197	0.002010	527,277	1,060	73.00
74.00	07400	RENAL DIALYSIS	22,314	3,169,215	0.007041	83,226	586	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03951	WOUND CARE	321,892	9,374,649	0.034336	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1,513,479	183,832,906	0.008233	9,436	78	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	10,992,832	0.000000	0	0	92.00
200.00		Total (lines 50-199)	9,111,269	1,640,903,879		5,032,190	54,161	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/30/2017 10:19 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	55,185	0	55,185	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	55,185	0	55,185	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/30/2017 10:19 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	351,722,888	0.000000	0.000000	29,505	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	14,939,230	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	17,295,644	0.000000	0.000000	769	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	243,741,329	0.000000	0.000000	168,203	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	201,541,214	0.000000	0.000000	642,192	60.00
65.00	06500	RESPIRATORY THERAPY	0	38,403,163	0.000000	0.000000	684	65.00
66.00	06600	PHYSICAL THERAPY	0	18,508,149	0.000000	0.000000	1,590,284	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,069,281	0.000000	0.000000	1,558,434	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,231,203	0.000000	0.000000	345,690	68.00
69.00	06900	ELECTROCARDIOLOGY	0	146,143,379	0.000000	0.000000	54,620	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	44,707,386	0.000000	0.000000	17,396	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	174,149,214	0.000000	0.000000	4,474	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	170,082,197	0.000000	0.000000	527,277	73.00
74.00	07400	RENAL DIALYSIS	0	3,169,215	0.000000	0.000000	83,226	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.03	03951	WOUND CARE	0	9,374,649	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	55,185	183,832,906	0.000300	0.000300	9,436	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	10,992,832	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	55,185	1,640,903,879			5,032,190	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/30/2017 10:19 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03950	ANCILLARY	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
76.03	03951	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	3	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	3	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/30/2017 10:19 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.077240	0	0	15,783,066	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.317015	0	0	142,357	0	52.00
53.00	05300	ANESTHESIOLOGY	0.021053	0	0	940,132	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.077067	0	0	23,216,248	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.089147	0	0	14,002,057	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.088775	0	0	532,285	0	65.00
66.00	06600	PHYSICAL THERAPY	0.206008	0	0	479,555	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.103041	0	0	150,618	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.177838	0	0	291,489	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.091486	0	0	7,611,606	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.072689	0	0	1,344,650	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.182048	0	0	4,535,320	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.165559	0	0	8,817,330	0	73.00
74.00	07400	RENAL DIALYSIS	0.227995	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.292856	0	0	1,113,974	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.112054	0	0	33,895,448	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.289836	0	0	1,120,379	0	92.00
200.00		Subtotal (see instructions)		0	0	113,976,514	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	113,976,514	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/30/2017 10:19 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,219,084		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	45,129		52.00
53.00	05300	ANESTHESIOLOGY	0	19,793		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,789,207		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	1,248,241		60.00
65.00	06500	RESPIRATORY THERAPY	0	47,254		65.00
66.00	06600	PHYSICAL THERAPY	0	98,792		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	15,520		67.00
68.00	06800	SPEECH PATHOLOGY	0	51,838		68.00
69.00	06900	ELECTROCARDIOLOGY	0	696,355		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	97,741		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	825,646		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,459,788		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	326,234		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	3,798,121		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	324,726		92.00
200.00		Subtotal (see instructions)	0	12,063,469		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	12,063,469		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/30/2017 10:19 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)	50,559	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	50,559	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)	46,541	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)	23,301	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)	40,091,044	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)	40,091,044	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)	40,091,044	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)	792.96	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	18,476,761	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)	18,476,761	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/30/2017 10:19 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	12,969,785	6,917	1,875.06	3,650	6,843,969	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	3,781,145	2,388	1,583.39	0	0	43.01
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)	34,691,346	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	60,012,076	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)	2,171,706	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,585,128	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	3,756,834	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	56,255,242	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)	4,018	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	792.96	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,186,113	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/30/2017 10:19 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	3,915,878	40,091,044	0.097675	3,186,113	311,204	90.00
91.00	Nursing School cost	0	40,091,044	0.000000	3,186,113	0	91.00
92.00	Allied health cost	0	40,091,044	0.000000	3,186,113	0	92.00
93.00	All other Medical Education	0	40,091,044	0.000000	3,186,113	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0035 Component CCN: 15-T035	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/30/2017 10:19 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,607	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,607	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)	2,607	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)	1,719	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)	2,989,542	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)	2,989,542	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)	2,989,542	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)	1,146.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,971,246	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,971,246	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/30/2017 10:19 am

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	43.01
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)	736,644	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,707,890	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)	285,131	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	54,164	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	339,295	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,368,595	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0035
Component CCN: 15-T035
Period: From 01/01/2016 To 12/31/2016
Worksheet D-1
Date/Time Prepared: 5/30/2017 10:19 am
Title XVIII
Subprovider - IRF
PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	432,433	2,989,542	0.144649	0	0	90.00
91.00	Nursing School cost	0	2,989,542	0.000000	0	0	91.00
92.00	Allied health cost	0	2,989,542	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,989,542	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/30/2017 10:19 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		65,015,604		30.00
31.00	03100	INTENSIVE CARE UNIT		18,169,073		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0		31.01
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.077240	69,377,162	5,358,692	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.317015	36,662	11,622	52.00
53.00	05300	ANESTHESIOLOGY	0.021053	2,841,664	59,826	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.077067	26,061,814	2,008,506	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.089147	37,161,185	3,312,808	60.00
65.00	06500	RESPIRATORY THERAPY	0.088775	20,508,013	1,820,599	65.00
66.00	06600	PHYSICAL THERAPY	0.206008	5,937,012	1,223,072	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.103041	3,482,090	358,798	67.00
68.00	06800	SPEECH PATHOLOGY	0.177838	1,226,323	218,087	68.00
69.00	06900	ELECTROCARDIOLOGY	0.091486	22,996,682	2,103,874	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.072689	11,534,510	838,432	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.182048	49,040,118	8,927,655	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.165559	27,704,811	4,586,781	73.00
74.00	07400	RENAL DIALYSIS	0.227995	1,921,116	438,005	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.292856	215,015	62,968	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.112377	25,604,175	2,877,320	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.289836	1,670,950	484,301	92.00
200.00		Total (sum of lines 50-94 and 96-98)		307,319,302	34,691,346	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)		307,319,302		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/30/2017 10:19 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0		31.01
41.00	04100	SUBPROVIDER - IRF		4,455,105		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.077240	29,505	2,279	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.317015	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.021053	769	16	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.077067	168,203	12,963	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.089147	642,192	57,249	60.00
65.00	06500	RESPIRATORY THERAPY	0.088775	684	61	65.00
66.00	06600	PHYSICAL THERAPY	0.206008	1,590,284	327,611	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.103041	1,558,434	160,583	67.00
68.00	06800	SPEECH PATHOLOGY	0.177838	345,690	61,477	68.00
69.00	06900	ELECTROCARDIOLOGY	0.091486	54,620	4,997	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.072689	17,396	1,264	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.182048	4,474	814	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.165559	527,277	87,295	73.00
74.00	07400	RENAL DIALYSIS	0.227995	83,226	18,975	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.292856	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.112377	9,436	1,060	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.289836	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		5,032,190	736,644	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)		5,032,190		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/30/2017 10:19 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		5,228,691		30.00
31.00	03100	INTENSIVE CARE UNIT		4,805,716		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		9,028,374		31.01
41.00	04100	SUBPROVIDER - IRF		367,087		41.00
43.00	04300	NURSERY		856,315		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.077240	13,709,224	1,058,900	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.317015	3,808,537	1,207,363	52.00
53.00	05300	ANESTHESIOLOGY	0.021053	941,703	19,826	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.077067	6,591,053	507,953	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.089147	10,696,243	953,538	60.00
65.00	06500	RESPIRATORY THERAPY	0.088775	4,085,475	362,688	65.00
66.00	06600	PHYSICAL THERAPY	0.206008	1,041,991	214,658	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.103041	497,483	51,261	67.00
68.00	06800	SPEECH PATHOLOGY	0.177838	137,785	24,503	68.00
69.00	06900	ELECTROCARDIOLOGY	0.091486	4,381,444	400,841	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.072689	2,071,393	150,567	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.182048	4,142,211	754,081	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.165559	8,915,732	1,476,080	73.00
74.00	07400	RENAL DIALYSIS	0.227995	294,343	67,109	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.292856	132,444	38,787	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.112054	6,961,349	780,047	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.289836	488,986	141,726	92.00
200.00		Total (sum of lines 50-94 and 96-98)		68,897,396	8,209,928	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)		68,897,396		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/30/2017 10:19 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)	32,974,065	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	11,371,016	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)	2,374,722	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	227.02	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)	2.71	30.00
31.00	Percentage of Medicaid patient days (see instructions)	17.83	31.00
32.00	Sum of lines 30 and 31	20.54	32.00
33.00	Allowable disproportionate share percentage (see instructions)	6.16	33.00
34.00	Disproportionate share adjustment (see instructions)	682,915	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/30/2017 10:19 am
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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000238466	0.000257603	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,527,648	1,539,818	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,143,649	388,119	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,531,768		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)	48,934,486		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)	48,934,486	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	3,871,783	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	16,530	53.00
54.00	Special add-on payments for new technologies	8,693	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)	7,681	58.00
59.00	Total (sum of amounts on lines 49 through 58)	52,839,173	59.00
60.00	Primary payer payments	23,728	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	52,815,445	61.00
62.00	Deductibles billed to program beneficiaries	4,536,168	62.00
63.00	Coinsurance billed to program beneficiaries	321,391	63.00
64.00	Allowable bad debts (see instructions)	265,243	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	172,408	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	155,114	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	48,130,294	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)	-7,367	70.93
70.94	HRR adjustment amount (see instructions)	-251,223	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Date/Time Prepared: 5/30/2017 10:19 am

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		47,871,704	71.00
71.01	Sequestration adjustment (see instructions)		957,434	71.01
72.00	Interim payments		46,682,442	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)		231,828	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		2,620,395	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: 15-0035	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/30/2017 10:19 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	72,765	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	29,290,331	2.00
3.00	PPS payments	29,704,190	3.00
4.00	Outlier payment (see instructions)	258,368	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	7,413	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	72,765	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	453,207	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)	453,207	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)	453,207	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	380,442	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)	72,765	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)	29,969,971	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	5,674,382	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)	24,368,354	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)	24,368,354	30.00
31.00	Primary payer payments	17,808	31.00
32.00	Subtotal (line 30 minus line 31)	24,350,546	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)	493,729	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	320,924	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	398,313	36.00
37.00	Subtotal (see instructions)	24,671,470	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)	24,671,470	40.00
40.01	Sequestration adjustment (see instructions)	493,429	40.01
41.00	Interim payments	24,256,705	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-78,664	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: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I Date/Time Prepared: 5/30/2017 10:19 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		46,593,042		24,140,705	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	07/11/2016	89,400	07/11/2016	116,000	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)		89,400		116,000	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)		46,682,442		24,256,705	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		231,828		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		78,664	6.02
7.00	Total Medicare program liability (see instructions)		46,914,270		24,178,041	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2017 10:19 am

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,535,705		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,535,705		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		15,005		0	6.02
7.00	Total Medicare program liability (see instructions)		2,520,700		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0035	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/30/2017 10:19 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	12,366	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	26,951	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	6,251	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	55,846	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	1,834,785,600	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	4,564,920	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)	632,267	8.00
9.00	Sequestration adjustment amount (see instructions)	12,645	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	619,622	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)	619,622	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035 Component CCN: 15-T035	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part III Date/Time Prepared: 5/30/2017 10:19 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	2,572,378	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0131	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	49,132	3.00
4.00	Outlier Payments	27,978	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	7.122951	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	2,649,488	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	2,649,488	17.00
18.00	Primary payer payments	31,100	18.00
19.00	Subtotal (line 17 less line 18).	2,618,388	19.00
20.00	Deductibles	7,700	20.00
21.00	Subtotal (line 19 minus line 20)	2,610,688	21.00
22.00	Coinsurance	41,216	22.00
23.00	Subtotal (line 21 minus line 22)	2,569,472	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	4,104	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	2,668	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	2,572,140	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	3	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	2,572,143	32.00
32.01	Sequestration adjustment (see instructions)	51,443	32.01
33.00	Interim payments	2,535,705	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)	-15,005	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	5,916	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	27,978	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 5/30/2017 10:19 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-1,031,597	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	52,597,739	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,985,915	0	0	0	6.00
7.00	Inventory	8,710,281	0	0	0	7.00
8.00	Prepaid expenses	1,337,259	0	0	0	8.00
9.00	Other current assets	571,973	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)	54,199,740	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	11,615,241	0	0	0	12.00
13.00	Land improvements	4,917,686	0	0	0	13.00
14.00	Accumulated depreciation	-2,203,493	0	0	0	14.00
15.00	Buildings	191,903,322	0	0	0	15.00
16.00	Accumulated depreciation	-24,130,718	0	0	0	16.00
17.00	Leasehold improvements	5,442,020	0	0	0	17.00
18.00	Accumulated depreciation	-1,492,636	0	0	0	18.00
19.00	Fixed equipment	6,748,728	0	0	0	19.00
20.00	Accumulated depreciation	-3,417,120	0	0	0	20.00
21.00	Automobiles and trucks	372,137	0	0	0	21.00
22.00	Accumulated depreciation	-320,099	0	0	0	22.00
23.00	Major movable equipment	57,655,000	0	0	0	23.00
24.00	Accumulated depreciation	-39,020,534	0	0	0	24.00
25.00	Minor equipment depreciable	20,851,075	0	0	0	25.00
26.00	Accumulated depreciation	-13,115,915	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)	215,804,694	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	12,851,271	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	12,851,271	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	282,855,705	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	10,108,937	0	0	0	37.00
38.00	Salaries, wages, and fees payable	7,955,682	0	0	0	38.00
39.00	Payroll taxes payable	819,004	0	0	0	39.00
40.00	Notes and loans payable (short term)	38,335	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	-86,192,098	0	0	0	43.00
44.00	Other current liabilities	3,154,336	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-64,115,804	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	47,221	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	14,674,752	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	14,721,973	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-49,393,831	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	332,249,536				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)	332,249,536	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	282,855,705	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 5/30/2017 10:19 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		290,219,682		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		42,009,452				2.00
3.00	Total (sum of line 1 and line 2)		332,229,134		0		3.00
4.00	ADJ TO R/E	20,402		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)		20,402		0		10.00
11.00	Subtotal (line 3 plus line 10)		332,249,536		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		332,249,536		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	ADJ TO R/E		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/30/2017 10:19 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	133,538,472		133,538,472	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	6,753,755		6,753,755	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)	140,292,227		140,292,227	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	34,502,369		34,502,369	11.00
11.01	NEONATAL INTENSIVE CARE UNIT	19,087,125		19,087,125	11.01
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)	53,589,494		53,589,494	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	193,881,721		193,881,721	17.00
18.00	Ancillary services	624,809,203	821,268,938	1,446,078,141	18.00
19.00	Outpatient services	57,848,074	136,977,664	194,825,738	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.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	876,538,998	958,246,602	1,834,785,600	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		271,697,518		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)		271,697,518		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0035	Period: From 01/01/2016 To 12/31/2016	Worksheet G-3 Date/Time Prepared: 5/30/2017 10:19 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,834,785,600	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,522,961,408	2.00
3.00	Net patient revenues (line 1 minus line 2)	311,824,192	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	271,697,518	4.00
5.00	Net income from service to patients (line 3 minus line 4)	40,126,674	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC INCOME	1,882,778	24.00
25.00	Total other income (sum of lines 6-24)	1,882,778	25.00
26.00	Total (line 5 plus line 25)	42,009,452	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	42,009,452	29.00

CALCULATION OF CAPITAL PAYMENT | Provider CCN: 15-0035 | Period: From 01/01/2016 To 12/31/2016 | Worksheet L Parts I-III Date/Time Prepared: 5/30/2017 10:19 am

Title XVIII | Hospital | PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	3,553,639	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	167,114	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)	154.07	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)	2.71	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	17.83	8.00
9.00	Sum of lines 7 and 8	20.54	9.00
10.00	Allowable disproportionate share percentage (see instructions)	4.25	10.00
11.00	Disproportionate share adjustment (see instructions)	151,030	11.00
12.00	Total prospective capital payments (see instructions)	3,871,783	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