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: 15-0048	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/25/2017 3:16 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/25/2017 Time: 3:16 pm
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 REID HOSPITAL & HEALTH CARE SERVICES (15-0048) 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: 5/25/2017 Time: 3:16 pm
SXOcWPxMSZZysIqJluupE8EuTMAIlO
xib:TOC5rWopc.ouR8A:GYExaTMJ5A
XmmT1ZtgSeOmzDiD

PI: Date: 5/25/2017 Time: 3:16 pm
GYSewYdXneOQJ5hIDTwa:fe1qqD8p0
V4i7uOduFprjkbweCcF3ccFCDXTUBz
aM9jOL79yOORy5Xh

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

Title: CFO

Date: 5/25/17

		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	166,847	300,963	639,960	0	1.00
2.00	Subprovider - IPF	0	138,402	77		0	2.00
3.00	Subprovider - IRF	0	78,743	-20		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	383,992	301,020	639,960	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: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2017 3:15 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1401 CHESTER BOULEVARD	PO Box:			1.00
2.00	City: RICHMOND	State: IN	Zip Code: 47374	County: WAYNE	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	REID HOSPITAL & HEALTH CARE SERVICES	150048	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	SUBPROVIDER	15S048	99915	4	01/01/2001	N	P	O	4.00
5.00	Subprovider - IRF	REHAB UNIT	15T048	99915	5	01/01/2003	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	HOSPICE	151524	99915		11/03/1993				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)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	876	325	528	144	5,674	102	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	53	7	0	207		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2017 3:15 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	01/01/2016	12/31/2016	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	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	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2017 3:15 pm

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N		0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	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	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

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

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

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			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:	0	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	Y	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.	Y	5.06	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: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2017 3:15 pm

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

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

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	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: 15-0048	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/25/2017 3:15 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2016	12/31/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 5/25/2017 3:15 pm

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

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

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

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	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.	Y		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.	Y		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.	Y		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/18/2017	Y	04/18/2017	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 5/25/2017 3:15 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	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	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	Y	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.	N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BKD, LLP	BKD, LLP	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5025810435	LVCOSTREPORTS@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0048	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/25/2017 3:15 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BKD, LLP		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: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/25/2017 3:15 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	135	49,410	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)		135	49,410	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	30	10,980	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		165	60,390	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	38	13,908		0	16.00
17.00	SUBPROVIDER - IRF	41.00	20	7,320		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	116.00	0	0			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)		223				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: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2017 3:15 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	18,255	713	29,819			1.00
2.00	HMO and other (see instructions)	3,042	6,671				2.00
3.00	HMO IPF Subprovider	689	0				3.00
4.00	HMO IRF Subprovider	190	267				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)	18,255	713	29,819			7.00
8.00	INTENSIVE CARE UNIT	2,007	114	4,709			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		49	2,026			13.00
14.00	Total (see instructions)	20,262	876	36,554	4.39	2,293.77	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	7,681	0	10,560	0.00	64.57	16.00
17.00	SUBPROVIDER - IRF	2,326	0	3,517	0.00	20.64	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	14,518	683	16,357	0.00	19.24	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)				4.39	2,398.22	27.00
28.00	Observation Bed Days		149	2,834			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			611			30.00
31.00	Employee discount days - IRF			29			31.00
32.00	Labor & delivery days (see instructions)	0	102	149			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: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2017 3:15 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	5,394	303	10,232	1.00
2.00	HMO and other (see instructions)			716	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	5,394	303	10,232	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	487	0	784	16.00
17.00	SUBPROVIDER - IRF	0.00	0	180	0	255	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	0.00					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: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 5/25/2017 3:15 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	154,415,758	0	154,415,758	4,997,413.98	30.90	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	314,039	314,039	11,185.50	28.08	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)		74,815,040	78,412	74,893,452	1,742,718.90	42.98	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		5,725,161	0	5,725,161	126,303.56	45.33	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		21,604,047	0	21,604,047			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		13,602,406	0	13,602,406			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		79,878	0	79,878			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	1,947,244	0	1,947,244	59,661.22	32.64	26.00
27.00	Administrative & General	5.00	15,780,519	-243,381	15,537,138	562,963.48	27.60	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 5/25/2017 3:15 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		4,415,489	0	4,415,489	61,192.97	72.16	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,159,339	0	2,159,339	101,814.00	21.21	30.00
31.00	Laundry & Linen Service	8.00	395,593	-78,412	317,181	23,466.78	13.52	31.00
32.00	Housekeeping	9.00	1,474,789	0	1,474,789	108,168.32	13.63	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,447,398	-1,992,897	454,501	30,968.88	14.68	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,992,897	1,992,897	135,799.44	14.68	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	159,275	243,381	402,656	6,808.42	59.14	38.00
39.00	Central Services and Supply	14.00	588,438	0	588,438	40,998.42	14.35	39.00
40.00	Pharmacy	15.00	3,808,036	0	3,808,036	121,713.85	31.29	40.00
41.00	Medical Records & Medical Records Library	16.00	2,107,005	0	2,107,005	125,539.61	16.78	41.00
42.00	Social Service	17.00	3,047,347	0	3,047,347	33,973.86	89.70	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part III Date/Time Prepared: 5/25/2017 3:15 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		158,831,247	-314,039	158,517,208	5,047,421.45	31.41	1.00
2.00	Excluded area salaries (see instructions)		74,815,040	78,412	74,893,452	1,742,718.90	42.98	2.00
3.00	Subtotal salaries (line 1 minus line 2)		84,016,207	-392,451	83,623,756	3,304,702.55	25.30	3.00
4.00	Subtotal other wages & related costs (see inst.)		5,725,161	0	5,725,161	126,303.56	45.33	4.00
5.00	Subtotal wage-related costs (see inst.)		21,604,047	0	21,604,047	0.00	25.83	5.00
6.00	Total (sum of lines 3 thru 5)		111,345,415	-392,451	110,952,964	3,431,006.11	32.34	6.00
7.00	Total overhead cost (see instructions)		38,330,472	-78,412	38,252,060	1,413,069.25	27.07	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part IV Date/Time Prepared: 5/25/2017 3:15 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	6,572,730	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)	0	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)	15,838,505	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	730,386	9.00
10.00	Dental, Hearing and Vision Plan	764,394	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	158,400	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	327,849	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	837,687	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	9,473,070	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	60,111	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	523,199	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	35,286,331	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: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part V Date/Time Prepared: 5/25/2017 3:15 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	5,725,161	35,286,331	1.00
2.00	Hospital	5,725,161	34,658,783	2.00
3.00	Subprovider - IPF	0	367,285	3.00
4.00	Subprovider - IRF	0	134,266	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	0	125,997	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-BASED HOSPICE IDENTIFICATION DATA | Provider CCN: 15-0048 Hospice CCN: 15-1524 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 5/25/2017 3:15 pm

Hospice I

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	1	0	54	55	10.00
11.00	Hospice Routine Home Care	13,803	672	979	15,454	11.00
12.00	Hospice Inpatient Respite Care	74	0	3	77	12.00
13.00	Hospice General Inpatient Care	640	11	120	771	13.00
14.00	Total Hospice Days	14,518	683	1,156	16,357	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 5/25/2017 3:15 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.292451	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	12,898,869	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	51,478,575	6.00
7.00	Medicaid cost (line 1 times line 6)	15,054,961	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)	2,156,092	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,156,092	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)	4,780,022	5,349,377	10,129,399	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	1,397,922	1,564,431	2,962,353	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,397,922	1,564,431	2,962,353	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)	21,126,503	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	1,664,531	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	19,461,972	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	5,691,673	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	8,654,026	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	10,810,118	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/25/2017 3:15 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		0	0	6,910,668	6,910,668	1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE		0	0	19,034,154	19,034,154	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,947,244	21,784,459	23,731,703	1,264,255	24,995,958	4.00
5.01	00540	NONPATIENT TELEPHONES	243,262	20,473	263,735	0	263,735	5.01
5.02	00550	DATA PROCESSING	3,904,861	17,480,568	21,385,429	2,425,322	23,810,751	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	882,963	685,376	1,568,339	171,531	1,739,870	5.03
5.04	00570	ADMITTING	1,846,331	1,224,795	3,071,126	-10,870	3,060,256	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,098,759	4,000,144	6,098,903	-86,929	6,011,974	5.05
5.06	00590	OTHER A&G	6,804,343	12,660,708	19,465,051	3,184,344	22,649,395	5.06
7.00	00700	OPERATION OF PLANT	2,159,339	2,897,509	5,056,848	-26,675	5,030,173	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	395,593	469,471	865,064	-184,095	680,969	8.00
9.00	00900	HOUSEKEEPING	1,474,789	562,878	2,037,667	0	2,037,667	9.00
10.00	01000	DIETARY	2,447,398	3,045,145	5,492,543	-4,472,559	1,019,984	10.00
11.00	01100	CAFETERIA	0	0	0	4,472,559	4,472,559	11.00
13.00	01300	NURSING ADMINISTRATION	159,275	117,446	276,721	243,381	520,102	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	588,438	2,929,020	3,517,458	0	3,517,458	14.00
15.00	01500	PHARMACY	3,808,036	28,119,167	31,927,203	22,843	31,950,046	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,107,005	1,649,841	3,756,846	-8,885	3,747,961	16.00
17.00	01700	SOCIAL SERVICE	2,148,342	550,302	2,698,644	0	2,698,644	17.00
17.01	01701	INSERVICE EDUCATION	899,005	1,548,218	2,447,223	0	2,447,223	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	335,815	335,815	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	352,371	544,575	896,946	-335,815	561,131	22.00
23.00	02300	PARAMED ED PRGM	210,364	36,132	246,496	0	246,496	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,350,822	5,983,051	21,333,873	-16,779	21,317,094	30.00
31.00	03100	INTENSIVE CARE UNIT	3,052,332	2,277,428	5,329,760	0	5,329,760	31.00
40.00	04000	SUBPROVIDER - IPF	3,235,157	421,908	3,657,065	0	3,657,065	40.00
41.00	04100	SUBPROVIDER - IRF	1,199,857	331,186	1,531,043	0	1,531,043	41.00
43.00	04300	NURSERY	375,865	100,219	476,084	0	476,084	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,655,346	42,165,132	43,820,478	-10,337,313	33,483,165	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	505,975	228,845	734,820	0	734,820	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,451,506	6,051,472	11,502,978	-135,029	11,367,949	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,512,286	9,122,204	10,634,490	-5,233,383	5,401,107	59.00
60.00	06000	LABORATORY	3,380,403	7,493,473	10,873,876	-38,626	10,835,250	60.00
65.00	06500	RESPIRATORY THERAPY	1,354,264	493,001	1,847,265	-318	1,846,947	65.00
66.00	06600	PHYSICAL THERAPY	4,773,665	1,131,193	5,904,858	-205,979	5,698,879	66.00
69.00	06900	ELECTROCARDIOLOGY	843,272	651,628	1,494,900	-204	1,494,696	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	271,168	92,938	364,106	0	364,106	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	15,554,267	15,554,267	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	656,069	656,069	0	656,069	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	185,409	90,464	275,873	-37,939	237,934	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,540,138	2,298,655	6,838,793	0	6,838,793	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	PATIENT CARE CENTER - OCC	1,188,146	345,847	1,533,993	-148,569	1,385,424	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	892,767	2,049,693	2,942,460	-69,441	2,873,019	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		6,015,613	6,015,613	-6,015,613	0	113.00
116.00	11600	HOSPICE	1,052,772	1,077,915	2,130,687	0	2,130,687	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	85,298,868	189,404,161	274,703,029	26,254,118	300,957,147	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	6,988,045	6,988,045	-4,063,886	2,924,159	192.00
194.00	07950	RENTAL SPACE	0	15,551,369	15,551,369	-13,680,867	1,870,502	194.00
194.01	07951	FOUNDATION	154,627	162,308	316,935	-190	316,745	194.01
194.02	07952	RETAIL SERVICES	104,987	13,754	118,741	0	118,741	194.02
194.03	07953	REID CONTRACTED SERVICES	144,879	10,391	155,270	184,095	339,365	194.03
194.04	07954	REID PHYSICIAN ASSOC.	67,731,467	46,735,783	114,467,250	-8,068,106	106,399,144	194.04
194.05	07955	OTHER NRCC	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.08	07958	CAMBRIDGE RHC	980,930	933,287	1,914,217	-625,164	1,289,053	194.08
200.00		TOTAL (SUM OF LINES 118-199)	154,415,758	259,799,098	414,214,856	0	414,214,856	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/25/2017 3:15 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-6,019,034	891,634		1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE	-2,964	19,031,190		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-5,466,166	19,529,792		4.00
5.01	00540	NONPATIENT TELEPHONES	0	263,735		5.01
5.02	00550	DATA PROCESSING	-1,032,831	22,777,920		5.02
5.03	00560	PURCHASING RECEIVING AND STORES	-479,337	1,260,533		5.03
5.04	00570	ADMITTING	-20	3,060,236		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	-87	6,011,887		5.05
5.06	00590	OTHER A&G	-10,423,166	12,226,229		5.06
7.00	00700	OPERATION OF PLANT	-14,782	5,015,391		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	680,969		8.00
9.00	00900	HOUSEKEEPING	-40	2,037,627		9.00
10.00	01000	DIETARY	-575,597	444,387		10.00
11.00	01100	CAFETERIA	-2,988,329	1,484,230		11.00
13.00	01300	NURSING ADMINISTRATION	0	520,102		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,517,458		14.00
15.00	01500	PHARMACY	-127,821	31,822,225		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-47,358	3,700,603		16.00
17.00	01700	SOCIAL SERVICE	0	2,698,644		17.00
17.01	01701	INSERVICE EDUCATION	-1,319,447	1,127,776		17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	335,815		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	-448,626	112,505		22.00
23.00	02300	PARAMED ED PRGM	-39,291	207,205		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-3,230,528	18,086,566		30.00
31.00	03100	INTENSIVE CARE UNIT	-490	5,329,270		31.00
40.00	04000	SUBPROVIDER - IPF	-262	3,656,803		40.00
41.00	04100	SUBPROVIDER - IRF	-119,417	1,411,626		41.00
43.00	04300	NURSERY	0	476,084		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-10,008,459	23,474,706		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	734,820		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-101,853	11,266,096		54.00
59.00	05900	CARDIAC CATHETERIZATION	-536	5,400,571		59.00
60.00	06000	LABORATORY	-863,304	9,971,946		60.00
65.00	06500	RESPIRATORY THERAPY	-546	1,846,401		65.00
66.00	06600	PHYSICAL THERAPY	-52,199	5,646,680		66.00
69.00	06900	ELECTROCARDIOLOGY	-60,747	1,433,949		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-94	364,012		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	15,554,267		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	656,069		74.00
76.00	03950	ANCILLARY - OTHER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	-2,396	235,538		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-1,266,793	5,572,000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	PATIENT CARE CENTER - OCC	0	1,385,424		93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	-877,804	1,995,215		96.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	-441	2,130,246		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-45,570,765	255,386,382		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,924,159		192.00
194.00	07950	RENTAL SPACE	0	1,870,502		194.00
194.01	07951	FOUNDATION	0	316,745		194.01
194.02	07952	RETAIL SERVICES	0	118,741		194.02
194.03	07953	REID CONTRACTED SERVICES	0	339,365		194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	106,399,144		194.04
194.05	07955	OTHER NRCC	0	0		194.05
194.06	07956	VACANT SPACE	0	0		194.06
194.08	07958	CAMBRIDGE RHC	0	1,289,053		194.08
200.00		TOTAL (SUM OF LINES 118-199)	-45,570,765	368,644,091		200.00

RECLASSIFICATIONS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/25/2017 3:15 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - ALLOCATION & SUPPORT RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	434,246	1.00
2.00	DATA PROCESSING	5.02	0	2,437,509	2.00
3.00	PURCHASING RECEIVING AND STORES	5.03	0	171,531	3.00
4.00	OTHER A&G	5.06	0	4,164,549	4.00
5.00	PHARMACY	15.00	0	31,904	5.00
	0		0	7,239,739	
	B - CAPITAL EXPENSE RECLASS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	779,422	1.00
2.00	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	16,592,992	2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	33,099	3.00
4.00	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	315,682	4.00
5.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	82,534	5.00
6.00	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	2,125,480	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
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
	0		0	19,929,209	
	C - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	1,992,897	2,479,662	1.00
	0		1,992,897	2,479,662	
	D - LAUNDRY RECLASS				
1.00	REID CONTRACTED SERVICES	194.03	78,412	105,683	1.00
	0		78,412	105,683	
	E - NURSING VP RECLASS				
1.00	NURSING ADMINISTRATION	13.00	243,381	0	1.00
	0		243,381	0	
	H - IMPLANTABLE DEVICES RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	15,554,267	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	15,554,267	
	J - INTEREST RECLASS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	6,015,613	1.00
	0		0	6,015,613	
	K - INTERN AND RESIDENT				
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	314,039	21,776	1.00
	0		314,039	21,776	
	L - WORKERS COMP				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	837,687	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	837,687	
500.00	Grand Total: Increases		2,628,729	52,183,636	500.00

RECLASSIFICATIONS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/25/2017 3:15 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - ALLOCATION & SUPPORT RECLASS						
1.00	REID PHYSICIAN ASSOC.	194.04	0	4,965,635	0		1.00
2.00	REID PHYSICIAN ASSOC.	194.04	0	865,111	0		2.00
3.00	CAMBRIDGE RHC	194.08	0	619,593	0		3.00
4.00	REID PHYSICIAN ASSOC.	194.04	0	337,653	0		4.00
5.00	REID PHYSICIAN ASSOC.	194.04	0	451,747	0		5.00
	0		0	7,239,739			
	B - CAPITAL EXPENSE RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,678	9		1.00
2.00	DATA PROCESSING	5.02	0	12,187	9		2.00
3.00	ADMITTING	5.04	0	10,870	13		3.00
4.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	86,929	13		4.00
5.00	OTHER A&G	5.06	0	63,457	10		5.00
6.00	OPERATION OF PLANT	7.00	0	26,675	10		6.00
7.00	PHARMACY	15.00	0	9,061	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	8,885	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	16,779	0		9.00
10.00	OPERATING ROOM	50.00	0	35,666	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	115,792	0		11.00
12.00	LABORATORY	60.00	0	38,626	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	318	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	205,979	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	204	0		15.00
16.00	CARDIAC REHABILITATION	76.97	0	37,939	0		16.00
17.00	PATIENT CARE CENTER - OCC	93.00	0	148,569	0		17.00
18.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	69,441	0		18.00
19.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	4,063,886	0		19.00
20.00	RENTAL SPACE	194.00	0	13,680,867	0		20.00
21.00	FOUNDATION	194.01	0	190	0		21.00
22.00	REID PHYSICIAN ASSOC.	194.04	0	1,222,906	0		22.00
23.00	REID PHYSICIAN ASSOC.	194.04	0	9,927	0		23.00
24.00	CAMBRIDGE RHC	194.08	0	5,571	0		24.00
25.00	REID PHYSICIAN ASSOC.	194.04	0	50,807	0		25.00
	0		0	19,929,209			
	C - CAFETERIA RECLASS						
1.00	DIETARY	10.00	1,992,897	2,479,662	0		1.00
	0		1,992,897	2,479,662			
	D - LAUNDRY RECLASS						
1.00	LAUNDRY & LINEN SERVICE	8.00	78,412	105,683	0		1.00
	0		78,412	105,683			
	E - NURSING VP RECLASS						
1.00	OTHER A&G	5.06	243,381	0	0		1.00
	0		243,381	0			
	H - IMPLANTABLE DEVICES RECLASS						
1.00	OPERATING ROOM	50.00	0	10,301,647	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	19,237	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	5,233,383	0		3.00
	0		0	15,554,267			
	J - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	6,015,613	11		1.00
	0		0	6,015,613			
	K - INTERN AND RESIDENT						
1.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	314,039	21,776	0		1.00
	0		314,039	21,776			
	L - WORKERS COMP						
1.00	OTHER A&G	5.06	0	673,367	0		1.00
2.00	REID PHYSICIAN ASSOC.	194.04	0	164,320	0		2.00
	TOTALS		0	837,687			
500.00	Grand Total: Decreases		2,628,729	52,183,636			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 5/25/2017 3:15 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	13,419,665	159,372	0	159,372	0	1.00
2.00	Land Improvements	35,314,060	236,053	0	236,053	0	2.00
3.00	Buildings and Fixtures	248,316,742	32,640,769	0	32,640,769	0	3.00
4.00	Building Improvements	12,253,567	90,876	0	90,876	0	4.00
5.00	Fixed Equipment	2,094,880	0	0	0	4,265	5.00
6.00	Movable Equipment	159,945,803	11,423,887	0	11,423,887	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	471,344,717	44,550,957	0	44,550,957	4,265	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	471,344,717	44,550,957	0	44,550,957	4,265	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	13,579,037	0	1.00
2.00	Land Improvements	35,550,113	0	2.00
3.00	Buildings and Fixtures	280,957,511	0	3.00
4.00	Building Improvements	12,344,443	0	4.00
5.00	Fixed Equipment	2,090,615	0	5.00
6.00	Movable Equipment	171,369,690	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	515,891,409	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	515,891,409	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part II | Date/Time Prepared: 5/25/2017 3:15 pm

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

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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 5/25/2017 3:15 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	344,521,719	0	344,521,719	0.667818	0	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	171,369,690	0	171,369,690	0.332182	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	515,891,409	0	515,891,409	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	776,001	82,534	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	0	16,590,028	2,125,480	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	17,366,029	2,208,014	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	33,099	0	891,634	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	315,682	0	19,031,190	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	348,781	0	19,922,824	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/25/2017 3:15 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP BLDG & FIXT - OFFSITE (chapter 2)		0	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-9,330,601			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-6,412,857			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-2,988,329	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-47,320	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	B	-39,252	PARAMED ED PRGM	23.00	0	19.00
20.00	Vending machines	B	-16,928	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP BLDG & FIXT - OFFSITE		0	NEW CAP BLDG & FIXT - OFFSITE	1.01	0	26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/25/2017 3:15 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-558,361	DIETARY	10.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-282,959	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	MISCELLANEOUS INCOME	B	-1,032,831	DATA PROCESSING	5.02	0	33.02
33.03	MISCELLANEOUS INCOME	B	-127	ADULTS & PEDIATRICS	30.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-40	SUBPROVIDER - IRF	41.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-1,877,221	OTHER A&G	5.06	0	33.05
33.06	MISCELLANEOUS INCOME	B	-68	CARDIAC CATHETERIZATION	59.00	0	33.06
33.07	MISCELLANEOUS INCOME	B	-479,337	PURCHASING RECEIVING AND STORES	5.03	0	33.07
33.08	MISCELLANEOUS INCOME	B	-123,947	PHARMACY	15.00	0	33.08
33.09	MISCELLANEOUS INCOME	B	-35,214	INSERVICE EDUCATION	17.01	0	33.09
33.10	MISCELLANEOUS INCOME	B	-20	ADMITTING	5.04	0	33.10
33.11	MISCELLANEOUS INCOME	B	-47,582	PHYSICAL THERAPY	66.00	0	33.11
33.12	MISCELLANEOUS INCOME	B	-7,048	OPERATING ROOM	50.00	0	33.12
33.13	MISCELLANEOUS INCOME	B	-101,635	RADIOLOGY-DIAGNOSTIC	54.00	0	33.13
33.14	MISCELLANEOUS INCOME	B	-21,220	LABORATORY	60.00	0	33.14
33.15	MISCELLANEOUS INCOME	B	-1,005	EMERGENCY	91.00	0	33.15
33.16	MISCELLANEOUS INCOME	B	-874,015	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.16
33.17	MISCELLANEOUS INCOME	B	-26,758	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	33.17
33.18	MISCELLANEOUS INCOME	B	-14,782	OPERATION OF PLANT	7.00	0	33.18
33.19	MISCELLANEOUS INCOME	B	-40	HOUSEKEEPING	9.00	0	33.19
33.21	INTEREST INCOME	A	-2,619,799	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.21
33.22	UNNECESSARY BORROWING	A	-3,395,814	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.22
33.23	SELF INSURANCE ADJUSTMENT	A	-5,128,058	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.23
33.24	CARRYFORWARD DEPRECIATION	A	-3,333	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.24
33.25	PATIENT ENTERTAINMENT SYSTEM	A	-177,160	OTHER A&G	5.06	0	33.25
33.26	LIFELINE SUPPORT	A	-2,999	OTHER A&G	5.06	0	33.26
33.27	LIFELINE SUPPORT	A	-2,964	NEW CAP BLDG & FIXT - OFFSITE	1.01	9	33.27
33.28	LIFELINE SUPPORT	A	-88	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.28
33.29	COUNTRY CLUB DUES	A	-5,343	OTHER A&G	5.06	0	33.29
33.30	AHA/IHA LOBBYING	A	-13,607	OTHER A&G	5.06	0	33.30
33.31	MARKETING/ADVERTISING	A	-44,599	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.31
33.32	MARKETING/ADVERTISING	A	-75	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	33.32
33.33	MARKETING/ADVERTISING	A	-2,635,826	OTHER A&G	5.06	0	33.33
33.34	MARKETING/ADVERTISING	A	-308	DIETARY	10.00	0	33.34
33.35	MARKETING/ADVERTISING	A	-3,874	PHARMACY	15.00	0	33.35
33.36	MARKETING/ADVERTISING	A	-4,095	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	33.36
33.37	MARKETING/ADVERTISING	A	-9,484	ADULTS & PEDIATRICS	30.00	0	33.37
33.38	MARKETING/ADVERTISING	A	-262	SUBPROVIDER - IPF	40.00	0	33.38
33.39	MARKETING/ADVERTISING	A	-1,862	SUBPROVIDER - IRF	41.00	0	33.39
33.40	MARKETING/ADVERTISING	A	-5,535	OPERATING ROOM	50.00	0	33.40
33.41	MARKETING/ADVERTISING	A	-3,564	PHYSICAL THERAPY	66.00	0	33.41
33.42	MARKETING/ADVERTISING	A	-2,396	CARDIAC REHABILITATION	76.97	0	33.42
33.43	MARKETING/ADVERTISING	A	-2,254	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.43
33.44	MARKETING/ADVERTISING	A	-317	HOSPICE	116.00	0	33.44
33.45	NON-ALLOWABLE EXPENSES	A	-10,550	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.45
33.46	NON-ALLOWABLE EXPENSES	A	-12	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	33.46
33.47	NON-ALLOWABLE EXPENSES	A	-89,166	OTHER A&G	5.06	0	33.47
33.48	NON-ALLOWABLE EXPENSES	A	-38	MEDICAL RECORDS & LIBRARY	16.00	0	33.48
33.49	NON-ALLOWABLE EXPENSES	A	-971,270	INSERVICE EDUCATION	17.01	0	33.49
33.50	NON-ALLOWABLE EXPENSES	A	-446	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	33.50
33.51	NON-ALLOWABLE EXPENSES	A	-39	PARAMED ED PRGM	23.00	0	33.51
33.52	NON-ALLOWABLE EXPENSES	A	-4,388	ADULTS & PEDIATRICS	30.00	0	33.52
33.53	NON-ALLOWABLE EXPENSES	A	-490	INTENSIVE CARE UNIT	31.00	0	33.53
33.54	NON-ALLOWABLE EXPENSES	A	-40	SUBPROVIDER - IRF	41.00	0	33.54

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/25/2017 3:15 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.55	NON-ALLOWABLE EXPENSES	A	-341	OPERATING ROOM	50.00	0	33.55
33.56	NON-ALLOWABLE EXPENSES	A	-218	RADIOLOGY-DIAGNOSTIC	54.00	0	33.56
33.57	NON-ALLOWABLE EXPENSES	A	-468	CARDIAC CATHETERIZATION	59.00	0	33.57
33.58	NON-ALLOWABLE EXPENSES	A	-546	RESPIRATORY THERAPY	65.00	0	33.58
33.59	NON-ALLOWABLE EXPENSES	A	-1,053	PHYSICAL THERAPY	66.00	0	33.59
33.60	NON-ALLOWABLE EXPENSES	A	-297	ELECTROCARDIOLOGY	69.00	0	33.60
33.61	NON-ALLOWABLE EXPENSES	A	-94	ELECTROENCEPHALOGRAPHY	70.00	0	33.61
33.62	NON-ALLOWABLE EXPENSES	A	-1,390	EMERGENCY	91.00	0	33.62
33.63	NON-ALLOWABLE EXPENSES	A	-1,535	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.63
33.64	NON-ALLOWABLE EXPENSES	A	-124	HOSPICE	116.00	0	33.64
33.65	HAF EXPENSE	A	-6,561,611	OTHER A&G	5.06	0	33.65
33.67	BOND REFUNDING 2015	A	922,001	OTHER A&G	5.06	0	33.67
33.68	BOND REFUNDING 2016	A	17,766	OTHER A&G	5.06	0	33.68
33.69	OCC MEDICINE - EMPLOYEE COST	A	-483,303	EMERGENCY	91.00	0	33.69
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-45,570,765				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: 15-0048	Period: From 01/01/2016 To 12/31/2016	Worksheet A-8-1 Date/Time Prepared: 5/25/2017 3:15 pm

	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	50.00	OPERATING ROOM	REID OUTPATIENT SURGERY	16,987,793	23,400,650	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
4.01	0.00			0	0	4.01
4.02	0.00			0	0	4.02
5.00	0		0	16,987,793	23,400,650	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	A	REID O/P SURGER	55.00		0.00	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: 15-0048	Period: From 01/01/2016 To 12/31/2016	Worksheet A-8-1 Date/Time Prepared: 5/25/2017 3:15 pm

	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	-6,412,857	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
5.00	-6,412,857			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			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: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 5/25/2017 3:15 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	17.01	INSERVICE EDUCATION	312,963	312,963	0	179,000	0	1.00
2.00	22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	417,327	417,327	0	197,500	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	3,216,529	3,216,529	0	179,000	0	3.00
4.00	41.00	SUBPROVIDER - IRF	117,475	117,475	0	179,000	0	4.00
5.00	50.00	OPERATING ROOM	3,582,678	3,582,678	0	246,400	0	5.00
6.00	60.00	LABORATORY	842,084	842,084	0	260,300	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	60,450	60,450	0	179,000	0	7.00
8.00	91.00	EMERGENCY	781,095	781,095	0	179,000	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			9,330,601	9,330,601	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	17.01	INSERVICE EDUCATION	0	0	0	0	0	1.00
2.00	22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	17.01	INSERVICE EDUCATION	0	0	0	312,963		1.00
2.00	22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	417,327		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	3,216,529		3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	117,475		4.00
5.00	50.00	OPERATING ROOM	0	0	0	3,582,678		5.00
6.00	60.00	LABORATORY	0	0	0	842,084		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	60,450		7.00
8.00	91.00	EMERGENCY	0	0	0	781,095		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	9,330,601		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/25/2017 3:15 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	891,634	891,634				1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE	19,031,190	0	19,031,190			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0			0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	19,529,792	3,234	27,636	0	19,560,662	4.00
5.01	00540	NONPATIENT TELEPHONES	263,735	4,601	0	0	31,209	5.01
5.02	00550	DATA PROCESSING	22,777,920	15,166	75,653	0	500,966	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	1,260,533	18,961	0	0	113,278	5.03
5.04	00570	ADMITTING	3,060,236	174	130,165	0	236,871	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	6,011,887	987	563,772	0	269,256	5.05
5.06	00590	OTHER A&G	12,226,229	30,395	487,428	0	841,725	5.06
7.00	00700	OPERATION OF PLANT	5,015,391	220,709	287,275	0	277,028	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	680,969	14,945	0	0	40,692	8.00
9.00	00900	HOUSEKEEPING	2,037,627	8,209	0	0	189,205	9.00
10.00	01000	DIETARY	444,387	15,227	0	0	58,309	10.00
11.00	01100	CAFETERIA	1,484,230	11,962	0	0	255,675	11.00
13.00	01300	NURSING ADMINISTRATION	520,102	2,369	0	0	51,658	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,517,458	10,190	0	0	75,492	14.00
15.00	01500	PHARMACY	31,822,225	8,809	0	0	488,544	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,700,603	4,249	406,455	0	270,314	16.00
17.00	01700	SOCIAL SERVICE	2,698,644	1,504	0	0	275,617	17.00
17.01	01701	INSERVICE EDUCATION	1,127,776	12,611	0	0	115,336	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	335,815	0	0	0	40,289	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	112,505	0	0	0	4,918	22.00
23.00	02300	PARAMED ED PRGM	207,205	1,285	185,161	0	26,988	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,086,566	132,358	0	0	1,969,403	30.00
31.00	03100	INTENSIVE CARE UNIT	5,329,270	29,746	0	0	391,593	31.00
40.00	04000	SUBPROVIDER - IPF	3,656,803	27,066	0	0	415,048	40.00
41.00	04100	SUBPROVIDER - IRF	1,411,626	21,684	0	0	153,933	41.00
43.00	04300	NURSERY	476,084	3,248	0	0	48,221	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,474,706	58,719	904,454	0	212,369	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	734,820	10,075	0	0	64,913	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,266,096	73,638	110,544	0	699,390	54.00
59.00	05900	CARDIAC CATHETERIZATION	5,400,571	16,452	0	0	194,016	59.00
60.00	06000	LABORATORY	9,971,946	16,895	0	0	433,682	60.00
65.00	06500	RESPIRATORY THERAPY	1,846,401	1,995	0	0	173,743	65.00
66.00	06600	PHYSICAL THERAPY	5,646,680	9,794	2,923,602	0	612,428	66.00
69.00	06900	ELECTROCARDIOLOGY	1,433,949	8,494	0	0	108,186	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	364,012	0	268,897	0	34,789	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	15,554,267	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	656,069	1,805	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	235,538	5,480	0	0	23,787	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,572,000	27,590	0	0	582,468	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	PATIENT CARE CENTER - OCC	1,385,424	10,825	58,519	0	152,431	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,995,215	2,149	198,426	0	114,536	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,130,246	539	0	0	135,063	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	255,386,382	844,139	6,627,987	0	10,683,369	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	2,924,159	302	169,684	0	0	192.00
194.00	07950	RENTAL SPACE	1,870,502	0	1,314,778	0	0	194.00
194.01	07951	FOUNDATION	316,745	250	0	0	19,838	194.01
194.02	07952	RETAIL SERVICES	118,741	2,835	0	0	13,469	194.02
194.03	07953	REID CONTRACTED SERVICES	339,365	0	0	0	28,647	194.03
194.04	07954	REID PHYSICIAN ASSOC.	106,399,144	41,785	9,732,608	0	8,689,493	194.04
194.05	07955	OTHER NRCC	0	645	0	0	0	194.05
194.06	07956	VACANT SPACE	0	1,678	1,186,133	0	0	194.06
194.08	07958	CAMBRIDGE RHC	1,289,053	0	0	0	125,846	194.08
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/25/2017 3:15 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
			NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	1.01	2.00	4.00	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	368,644,091	891,634	19,031,190	0	19,560,662	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/25/2017 3:15 pm

		Cost Center Description	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	299,545					5.01
5.02	00550	DATA PROCESSING	24,613	23,394,318				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	3,268	2,438,829	3,834,869			5.03
5.04	00570	ADMITTING	9,192	358,651	3,967	3,799,256		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	14,400	153,708	5,836	0	7,019,846	5.05
5.06	00590	OTHER A&G	12,051	286,921	24,750	0	0	5.06
7.00	00700	OPERATION OF PLANT	5,923	0	38,077	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	613	20,494	1,083	0	0	8.00
9.00	00900	HOUSEKEEPING	613	30,742	57,170	0	0	9.00
10.00	01000	DIETARY	8,987	348,404	38,118	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,838	143,461	1,420	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,021	122,966	361,148	0	0	14.00
15.00	01500	PHARMACY	4,392	409,887	293,515	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,945	860,763	3,788	0	0	16.00
17.00	01700	SOCIAL SERVICE	3,472	286,921	2,690	0	0	17.00
17.01	01701	INSERVICE EDUCATION	4,698	1,516,583	5,317	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	1,086	0	0	22.00
23.00	02300	PARAMED ED PRGM	306	102,472	1,014	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,285	2,438,829	248,977	220,594	407,565	30.00
31.00	03100	INTENSIVE CARE UNIT	5,311	358,651	143,763	41,813	77,253	31.00
40.00	04000	SUBPROVIDER - IPF	2,247	153,708	39,162	56,681	104,722	40.00
41.00	04100	SUBPROVIDER - IRF	3,268	286,921	23,696	18,768	34,676	41.00
43.00	04300	NURSERY	0	0	19,516	10,698	19,765	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,302	891,505	574,135	724,194	1,338,426	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,392	327,910	44,056	32,028	59,174	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,626	1,557,572	401,629	589,377	1,088,921	54.00
59.00	05900	CARDIAC CATHETERIZATION	2,962	102,472	467,166	380,530	703,059	59.00
60.00	06000	LABORATORY	6,536	594,337	38,028	389,383	719,415	60.00
65.00	06500	RESPIRATORY THERAPY	613	122,966	102,267	77,171	142,580	65.00
66.00	06600	PHYSICAL THERAPY	9,192	1,065,707	18,632	86,590	159,983	66.00
69.00	06900	ELECTROCARDIOLOGY	919	502,112	47,713	115,026	212,520	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	715	81,977	3,401	19,210	35,491	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	722	1,334	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	134,490	248,481	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	542,302	1,001,945	73.00
74.00	07400	RENAL DIALYSIS	511	20,494	5,562	4,013	7,415	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,226	20,494	2,697	5,873	10,850	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,375	768,539	131,400	268,113	495,360	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	PATIENT CARE CENTER - OCC	5,821	399,640	26,465	25,204	46,567	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	2,553	122,966	127,583	31,777	58,711	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,328	30,742	109,111	24,699	45,633	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	216,514	16,928,344	3,413,938	3,799,256	7,019,846	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	6,638	10,247	1,947	0	0	192.00
194.00	07950	RENTAL SPACE	9,907	0	15,582	0	0	194.00
194.01	07951	FOUNDATION	715	61,483	104	0	0	194.01
194.02	07952	RETAIL SERVICES	0	368,899	616	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	65,771	6,025,345	392,856	0	0	194.04
194.05	07955	OTHER NRCC	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.08	07958	CAMBRIDGE RHC	0	0	9,826	0	0	194.08
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)	299,545	23,394,318	3,834,869	3,799,256	7,019,846	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/25/2017 3:15 pm

		Cost Center Description	Subtotal	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.05	5.06	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G	13,909,499	13,909,499				5.06
7.00	00700	OPERATION OF PLANT	5,844,403	229,165	6,073,568			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	758,796	29,753	120,627	909,176		8.00
9.00	00900	HOUSEKEEPING	2,323,566	91,109	63,467	0	2,478,142	9.00
10.00	01000	DIETARY	913,432	35,817	107,914	0	43,129	10.00
11.00	01100	CAFETERIA	1,751,867	68,692	96,551	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	720,848	28,265	19,118	0	103,098	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,088,275	160,305	82,253	23,141	3,437	14.00
15.00	01500	PHARMACY	33,027,372	1,295,036	68,846	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,253,117	205,980	11,364	0	15,293	16.00
17.00	01700	SOCIAL SERVICE	3,268,848	128,175	4,283	0	9,451	17.00
17.01	01701	INSERVICE EDUCATION	2,782,321	109,098	91,162	0	24,056	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	376,104	14,747	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	118,509	4,647	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	524,431	20,563	27,450	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,527,577	922,540	1,057,530	243,443	729,248	30.00
31.00	03100	INTENSIVE CARE UNIT	6,377,400	250,064	240,100	59,396	162,036	31.00
40.00	04000	SUBPROVIDER - IPF	4,455,437	174,702	218,469	52,725	113,065	40.00
41.00	04100	SUBPROVIDER - IRF	1,954,572	76,641	175,029	29,633	82,479	41.00
43.00	04300	NURSERY	577,532	22,646	26,218	39,710	3,093	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,197,810	1,105,664	397,273	164,470	208,259	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,277,368	50,087	81,324	0	53,439	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,802,793	619,643	429,505	58,281	120,453	54.00
59.00	05900	CARDIAC CATHETERIZATION	7,267,228	284,955	44,916	0	31,961	59.00
60.00	06000	LABORATORY	12,170,222	477,207	132,744	46,484	123,203	60.00
65.00	06500	RESPIRATORY THERAPY	2,467,736	96,762	11,676	0	21,135	65.00
66.00	06600	PHYSICAL THERAPY	10,532,608	412,994	471,556	7,091	19,245	66.00
69.00	06900	ELECTROCARDIOLOGY	2,428,919	95,240	5,447	0	42,786	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	808,492	31,702	52,808	2,155	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,056	81	0	0	18,730	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	15,937,238	624,915	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,544,247	60,551	0	0	24,572	73.00
74.00	07400	RENAL DIALYSIS	695,869	27,286	14,571	0	30,758	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	305,945	11,996	0	0	9,107	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,853,845	307,957	222,693	109,809	252,076	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93.00	04040	PATIENT CARE CENTER - OCC	2,110,896	82,770	3,961	9,630	31,101	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	2,653,916	104,063	36,692	0	1,718	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,477,361	97,140	0	0	19,589	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	227,088,455	8,358,958	4,315,547	845,968	2,296,517	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	3,112,977	122,063	24,018	51,353	0	192.00
194.00	07950	RENTAL SPACE	3,210,769	125,897	219,251	0	0	194.00
194.01	07951	FOUNDATION	399,135	15,650	2,015	0	3,437	194.01
194.02	07952	RETAIL SERVICES	504,560	19,784	6,689	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	368,012	14,430	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	131,347,002	5,150,252	1,269,389	11,855	178,188	194.04
194.05	07955	OTHER NRCC	645	25	5,203	0	0	194.05
194.06	07956	VACANT SPACE	1,187,811	46,575	231,456	0	0	194.06
194.08	07958	CAMBRIDGE RHC	1,424,725	55,865	0	0	0	194.08
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	368,644,091	13,909,499	6,073,568	909,176	2,478,142	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/25/2017 3:15 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
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	1,100,292					10.00
11.00	01100	CAFETERIA	0	1,917,110				11.00
13.00	01300	NURSING ADMINISTRATION	0	3,452	874,781			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	20,789	0	4,378,200		14.00
15.00	01500	PHARMACY	0	61,718	0	5,146	34,458,118	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	63,658	0	0	8	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	INSERVICE EDUCATION	0	17,227	0	144	20	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	5,672	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	1,210	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	2,834	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	653,582	273,408	319,962	2,632	4,415	30.00
31.00	03100	INTENSIVE CARE UNIT	100,948	52,886	61,891	3,968	5,606	31.00
40.00	04000	SUBPROVIDER - IPF	226,378	68,101	79,697	0	884	40.00
41.00	04100	SUBPROVIDER - IRF	75,952	21,765	25,471	0	579	41.00
43.00	04300	NURSERY	43,432	5,453	6,381	20	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	88,868	104,000	2,103,803	103,889	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,327	8,574	1,252	31	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	93,824	109,800	3,788	590,939	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	24,734	28,946	1,602,375	46	59.00
60.00	06000	LABORATORY	0	75,595	0	253,529	75	60.00
65.00	06500	RESPIRATORY THERAPY	0	24,157	28,271	1,382	34,427	65.00
66.00	06600	PHYSICAL THERAPY	0	81,440	0	313	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	14,996	0	2	262,186	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4,977	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	30,637,766	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	3,880	4,540	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	83,098	97,248	278	21,204	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	PATIENT CARE CENTER - OCC	0	25,056	0	0	13,901	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	24,930	0	250,074	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	20,288	0	252	129,174	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,100,292	1,171,343	874,781	4,228,958	31,805,150	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	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	3,786	0	0	0	194.01
194.02	07952	RETAIL SERVICES	0	3,360	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	7,797	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	717,653	0	149,242	2,596,710	194.04
194.05	07955	OTHER NRCC	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.08	07958	CAMBRIDGE RHC	0	13,170	0	0	56,258	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,100,292	1,917,110	874,781	4,378,200	34,458,118	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/25/2017 3:15 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INSERVICE EDUCATION	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	
			16.00	17.00	17.01	21.00	22.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
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	5,549,420					16.00
17.00	01700	SOCIAL SERVICE	0	3,410,757				17.00
17.01	01701	INSERVICE EDUCATION	0	0	3,024,028			17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	396,523		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0		124,366	22.00
23.00	02300	PARAMED ED PRGM	0	0	19,688			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	322,187	1,847,682	674,569	259,231	81,305	30.00
31.00	03100	INTENSIVE CARE UNIT	61,070	438,768	168,868	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	82,785	0	143,376	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	27,412	0	41,516	0	0	41.00
43.00	04300	NURSERY	15,625	0	8,895	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,058,156	0	43,768	42,452	13,315	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	46,778	18,070	14,677	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	860,812	0	179,926	3,613	1,133	54.00
59.00	05900	CARDIAC CATHETERIZATION	555,780	0	44,032	0	0	59.00
60.00	06000	LABORATORY	568,710	0	123,203	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	112,712	0	60,145	30,710	9,632	65.00
66.00	06600	PHYSICAL THERAPY	126,469	0	133,753	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	168,001	0	27,832	21,678	6,799	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	28,056	0	4,944	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,055	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	196,429	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	792,056	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	5,861	0	4,061	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	8,577	0	6,798	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	391,591	1,106,237	160,680	38,839	12,182	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	PATIENT CARE CENTER - OCC	36,812	0	34,498	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	46,412	0	11,874	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	36,074	0	28,340	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,549,420	3,410,757	1,935,443	396,523	124,366	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
194.00	07950	RENTAL SPACE	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	795	0	0	194.01
194.02	07952	RETAIL SERVICES	0	0	1,611	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	814,612	0	0	194.04
194.05	07955	OTHER NRCC	0	0	238,173	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.08	07958	CAMBRIDGE RHC	0	0	33,394	0	0	194.08
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,549,420	3,410,757	3,024,028	396,523	124,366	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/25/2017 3:15 pm

		Cost Center Description	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
17.01	01701	INSERVICE EDUCATION						17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD						22.00
23.00	02300	PARAMED ED PRGM	594,966					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	30,919,311	-340,536	30,578,775		30.00
31.00	03100	INTENSIVE CARE UNIT	0	7,983,001	0	7,983,001		31.00
40.00	04000	SUBPROVIDER - IPF	0	5,615,619	0	5,615,619		40.00
41.00	04100	SUBPROVIDER - IRF	0	2,511,049	0	2,511,049		41.00
43.00	04300	NURSERY	0	749,005	0	749,005		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	33,631,727	-55,767	33,575,960		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,558,927	0	1,558,927		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	594,966	19,469,476	-4,746	19,464,730		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,884,973	0	9,884,973		59.00
60.00	06000	LABORATORY	0	13,970,972	0	13,970,972		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,898,745	-40,342	2,858,403		65.00
66.00	06600	PHYSICAL THERAPY	0	11,785,469	0	11,785,469		66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,073,886	-28,477	3,045,409		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	933,134	0	933,134		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21,922	0	21,922		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	16,758,582	0	16,758,582		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	33,059,192	0	33,059,192		73.00
74.00	07400	RENAL DIALYSIS	0	778,406	0	778,406		74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	350,843	0	350,843		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	10,657,737	-51,021	10,606,716		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	04040	PATIENT CARE CENTER - OCC	0	2,348,625	0	2,348,625		93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	3,129,679	0	3,129,679		96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	2,808,218	0	2,808,218		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	594,966	214,898,498	-520,889	214,377,609		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,310,412	0	3,310,412		192.00
194.00	07950	RENTAL SPACE	0	3,555,917	0	3,555,917		194.00
194.01	07951	FOUNDATION	0	424,818	0	424,818		194.01
194.02	07952	RETAIL SERVICES	0	536,004	0	536,004		194.02
194.03	07953	REID CONTRACTED SERVICES	0	390,239	0	390,239		194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	142,234,903	0	142,234,903		194.04
194.05	07955	OTHER NRCC	0	244,046	0	244,046		194.05
194.06	07956	VACANT SPACE	0	1,465,842	0	1,465,842		194.06
194.08	07958	CAMBRIDGE RHC	0	1,583,412	0	1,583,412		194.08
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)	594,966	368,644,091	-520,889	368,123,202		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/25/2017 3:15 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
				NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	NEW MVBLE EQUIP		
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,334	3,234	27,636	0	45,204	4.00
5.01	00540	NONPATIENT TELEPHONES	488	4,601	0	0	5,089	5.01
5.02	00550	DATA PROCESSING	3,544,147	15,166	75,653	0	3,634,966	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	14,174	18,961	0	0	33,135	5.03
5.04	00570	ADMITTING	26,065	174	130,165	0	156,404	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	57,445	987	563,772	0	622,204	5.05
5.06	00590	OTHER A&G	82,294	30,395	487,428	0	600,117	5.06
7.00	00700	OPERATION OF PLANT	123,839	220,709	287,275	0	631,823	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	105,571	14,945	0	0	120,516	8.00
9.00	00900	HOUSEKEEPING	9,260	8,209	0	0	17,469	9.00
10.00	01000	DIETARY	198,431	15,227	0	0	213,658	10.00
11.00	01100	CAFETERIA	0	11,962	0	0	11,962	11.00
13.00	01300	NURSING ADMINISTRATION	2,537	2,369	0	0	4,906	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	341,858	10,190	0	0	352,048	14.00
15.00	01500	PHARMACY	284,813	8,809	0	0	293,622	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	38,945	4,249	406,455	0	449,649	16.00
17.00	01700	SOCIAL SERVICE	6,001	1,504	0	0	7,505	17.00
17.01	01701	INSERVICE EDUCATION	37,147	12,611	0	0	49,758	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	13,218	0	0	0	13,218	22.00
23.00	02300	PARAMED ED PRGM	5,669	1,285	185,161	0	192,115	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	405,021	132,358	0	0	537,379	30.00
31.00	03100	INTENSIVE CARE UNIT	374,907	29,746	0	0	404,653	31.00
40.00	04000	SUBPROVIDER - IPF	40,519	27,066	0	0	67,585	40.00
41.00	04100	SUBPROVIDER - IRF	40,499	21,684	0	0	62,183	41.00
43.00	04300	NURSERY	8,114	3,248	0	0	11,362	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	850,507	58,719	904,454	0	1,813,680	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	50,532	10,075	0	0	60,607	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,031,473	73,638	110,544	0	1,215,655	54.00
59.00	05900	CARDIAC CATHETERIZATION	305,774	16,452	0	0	322,226	59.00
60.00	06000	LABORATORY	455,670	16,895	0	0	472,565	60.00
65.00	06500	RESPIRATORY THERAPY	51,534	1,995	0	0	53,529	65.00
66.00	06600	PHYSICAL THERAPY	75,708	9,794	2,923,602	0	3,009,104	66.00
69.00	06900	ELECTROCARDIOLOGY	138,014	8,494	0	0	146,508	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	41,775	0	268,897	0	310,672	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	3,726	1,805	0	0	5,531	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	26,805	5,480	0	0	32,285	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	169,409	27,590	0	0	196,999	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	27,567	10,825	58,519	0	96,911	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	22,321	2,149	198,426	0	222,896	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	7,380	539	0	0	7,919	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,033,491	844,139	6,627,987	0	16,505,617	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	91,902	302	169,684	0	261,888	192.00
194.00	07950	RENTAL SPACE	217,931	0	1,314,778	0	1,532,709	194.00
194.01	07951	FOUNDATION	1,171	250	0	0	1,421	194.01
194.02	07952	RETAIL SERVICES	0	2,835	0	0	2,835	194.02
194.03	07953	REID CONTRACTED SERVICES	167	0	0	0	167	194.03
194.04	07954	REID PHYSICIAN ASSOC.	1,664,268	41,785	9,732,608	0	11,438,661	194.04
194.05	07955	OTHER NRCC	0	645	0	0	645	194.05
194.06	07956	VACANT SPACE	0	1,678	1,186,133	0	1,187,811	194.06
194.08	07958	CAMBRIDGE RHC	31,413	0	0	0	31,413	194.08
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/25/2017 3:15 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	NEW MVBLE EQUIP		
		0	1.00	1.01	2.00	2A	
202.00	TOTAL (sum lines 118-201)	11,040,343	891,634	19,031,190	0	30,963,167	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/25/2017 3:15 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	
			4.00	5.01	5.02	5.03	5.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	45,204					4.00
5.01	00540	NONPATIENT TELEPHONES	72	5,161				5.01
5.02	00550	DATA PROCESSING	1,156	424	3,636,546			5.02
5.03	00560	PURCHASING RECEIVING AND STORES	261	56	379,106	412,558		5.03
5.04	00570	ADMITTING	547	158	55,751	427	213,287	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	621	248	23,893	628	0	5.05
5.06	00590	OTHER A&G	1,942	208	44,601	2,663	0	5.06
7.00	00700	OPERATION OF PLANT	639	102	0	4,096	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	94	11	3,186	116	0	8.00
9.00	00900	HOUSEKEEPING	437	11	4,779	6,150	0	9.00
10.00	01000	DIETARY	135	155	54,158	4,101	0	10.00
11.00	01100	CAFETERIA	590	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	119	32	22,300	153	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	174	18	19,115	38,853	0	14.00
15.00	01500	PHARMACY	1,127	76	63,715	31,577	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	624	120	133,802	407	0	16.00
17.00	01700	SOCIAL SERVICE	636	60	44,601	289	0	17.00
17.01	01701	INSERVICE EDUCATION	266	81	235,746	572	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	93	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	11	0	0	117	0	22.00
23.00	02300	PARAMED ED PRGM	62	5	15,929	109	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,544	401	379,106	26,785	12,385	30.00
31.00	03100	INTENSIVE CARE UNIT	903	92	55,751	15,466	2,348	31.00
40.00	04000	SUBPROVIDER - IPF	958	39	23,893	4,213	3,182	40.00
41.00	04100	SUBPROVIDER - IRF	355	56	44,601	2,549	1,054	41.00
43.00	04300	NURSERY	111	0	0	2,100	601	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	490	333	138,581	61,768	40,635	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	150	76	50,972	4,740	1,798	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,614	269	242,118	43,208	33,091	54.00
59.00	05900	CARDIAC CATHETERIZATION	448	51	15,929	50,258	21,365	59.00
60.00	06000	LABORATORY	1,001	113	92,387	4,091	21,862	60.00
65.00	06500	RESPIRATORY THERAPY	401	11	19,115	11,002	4,333	65.00
66.00	06600	PHYSICAL THERAPY	1,413	158	165,660	2,004	4,862	66.00
69.00	06900	ELECTROCARDIOLOGY	250	16	78,051	5,133	6,458	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	80	12	12,743	366	1,079	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	41	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	7,551	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	30,448	73.00
74.00	07400	RENAL DIALYSIS	0	9	3,186	598	225	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	55	21	3,186	290	330	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,344	144	119,466	14,136	15,053	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	PATIENT CARE CENTER - OCC	352	100	62,122	2,847	1,415	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	264	44	19,115	13,725	1,784	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	312	23	4,779	11,738	1,387	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,651	3,733	2,631,443	367,275	213,287	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	114	1,593	209	0	192.00
194.00	07950	RENTAL SPACE	0	171	0	1,676	0	194.00
194.01	07951	FOUNDATION	46	12	9,557	11	0	194.01
194.02	07952	RETAIL SERVICES	31	0	57,344	66	0	194.02
194.03	07953	REID CONTRACTED SERVICES	66	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	20,120	1,131	936,609	42,264	0	194.04
194.05	07955	OTHER NRCC	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.08	07958	CAMBRIDGE RHC	290	0	0	1,057	0	194.08
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)	45,204	5,161	3,636,546	412,558	213,287	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/25/2017 3:15 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.05	5.06	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	647,594					5.05
5.06	00590	OTHER A&G	0	649,531				5.06
7.00	00700	OPERATION OF PLANT	0	10,701	647,361			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,389	12,857	138,169		8.00
9.00	00900	HOUSEKEEPING	0	4,254	6,765	0	39,865	9.00
10.00	01000	DIETARY	0	1,672	11,502	0	694	10.00
11.00	01100	CAFETERIA	0	3,208	10,291	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,320	2,038	0	1,659	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,486	8,767	3,517	55	14.00
15.00	01500	PHARMACY	0	60,473	7,338	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,618	1,211	0	246	16.00
17.00	01700	SOCIAL SERVICE	0	5,985	457	0	152	17.00
17.01	01701	INSERVICE EDUCATION	0	5,094	9,717	0	387	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	689	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	217	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	960	2,926	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,581	43,079	112,718	36,996	11,730	30.00
31.00	03100	INTENSIVE CARE UNIT	7,123	11,677	25,591	9,026	2,607	31.00
40.00	04000	SUBPROVIDER - IPF	9,656	8,158	23,286	8,013	1,819	40.00
41.00	04100	SUBPROVIDER - IRF	3,197	3,579	18,656	4,503	1,327	41.00
43.00	04300	NURSERY	1,823	1,057	2,795	6,035	50	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	123,714	51,630	42,344	24,995	3,350	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,456	2,339	8,668	0	860	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	100,409	28,935	45,779	8,857	1,938	54.00
59.00	05900	CARDIAC CATHETERIZATION	64,829	13,306	4,787	0	514	59.00
60.00	06000	LABORATORY	66,337	22,284	14,149	7,064	1,982	60.00
65.00	06500	RESPIRATORY THERAPY	13,147	4,518	1,245	0	340	65.00
66.00	06600	PHYSICAL THERAPY	14,752	19,285	50,262	1,078	310	66.00
69.00	06900	ELECTROCARDIOLOGY	19,596	4,447	581	0	688	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,273	1,480	5,629	327	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	123	4	0	0	301	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	22,912	29,181	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	92,389	2,828	0	0	395	73.00
74.00	07400	RENAL DIALYSIS	684	1,274	1,553	0	495	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,000	560	0	0	147	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	45,677	14,380	23,736	16,688	4,055	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	PATIENT CARE CENTER - OCC	4,294	3,865	422	1,464	500	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	5,414	4,859	3,911	0	28	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	4,208	4,536	0	0	315	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	647,594	390,327	459,981	128,563	36,944	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	5,700	2,560	7,804	0	192.00
194.00	07950	RENTAL SPACE	0	5,879	23,369	0	0	194.00
194.01	07951	FOUNDATION	0	731	215	0	55	194.01
194.02	07952	RETAIL SERVICES	0	924	713	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	674	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	240,511	135,298	1,802	2,866	194.04
194.05	07955	OTHER NRCC	0	1	555	0	0	194.05
194.06	07956	VACANT SPACE	0	2,175	24,670	0	0	194.06
194.08	07958	CAMBRIDGE RHC	0	2,609	0	0	0	194.08
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)	647,594	649,531	647,361	138,169	39,865	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/25/2017 3:15 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
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	286,075					10.00
11.00	01100	CAFETERIA	0	26,051				11.00
13.00	01300	NURSING ADMINISTRATION	0	47	32,574			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	282	0	430,315		14.00
15.00	01500	PHARMACY	0	839	0	506	459,273	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	865	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	INSERVICE EDUCATION	0	234	0	14	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	77	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	16	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	39	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	169,931	3,715	11,913	259	59	30.00
31.00	03100	INTENSIVE CARE UNIT	26,246	719	2,305	390	75	31.00
40.00	04000	SUBPROVIDER - IPF	58,858	925	2,968	0	12	40.00
41.00	04100	SUBPROVIDER - IRF	19,748	296	948	0	8	41.00
43.00	04300	NURSERY	11,292	74	238	2	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,208	3,873	206,769	1,385	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	100	319	123	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,275	4,089	372	7,876	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	336	1,078	157,494	1	59.00
60.00	06000	LABORATORY	0	1,027	0	24,919	1	60.00
65.00	06500	RESPIRATORY THERAPY	0	328	1,053	136	459	65.00
66.00	06600	PHYSICAL THERAPY	0	1,107	0	31	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	204	0	0	3,495	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	68	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	408,351	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	53	169	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	1,129	3,621	27	283	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	PATIENT CARE CENTER - OCC	0	340	0	0	185	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	339	0	24,579	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	276	0	25	1,722	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	286,075	15,918	32,574	415,646	423,912	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
194.00	07950	RENTAL SPACE	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	51	0	0	0	194.01
194.02	07952	RETAIL SERVICES	0	46	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	106	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	9,751	0	14,669	34,611	194.04
194.05	07955	OTHER NRCC	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.08	07958	CAMBRIDGE RHC	0	179	0	0	750	194.08
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)	286,075	26,051	32,574	430,315	459,273	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/25/2017 3:15 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INSERVICE EDUCATION	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	
			16.00	17.00	17.01	21.00	22.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
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	596,542					16.00
17.00	01700	SOCIAL SERVICE	0	59,685				17.00
17.01	01701	INSERVICE EDUCATION	0	0	301,869			17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	859		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0		13,579	22.00
23.00	02300	PARAMED ED PRGM	0	0	1,965			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,645	32,333	67,338			30.00
31.00	03100	INTENSIVE CARE UNIT	6,567	7,678	16,857			31.00
40.00	04000	SUBPROVIDER - IPF	8,902	0	14,312			40.00
41.00	04100	SUBPROVIDER - IRF	2,948	0	4,144			41.00
43.00	04300	NURSERY	1,680	0	888			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	113,597	0	4,369			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,030	316	1,465			52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	92,563	0	17,961			54.00
59.00	05900	CARDIAC CATHETERIZATION	59,763	0	4,395			59.00
60.00	06000	LABORATORY	61,153	0	12,299			60.00
65.00	06500	RESPIRATORY THERAPY	12,120	0	6,004			65.00
66.00	06600	PHYSICAL THERAPY	13,599	0	13,352			66.00
69.00	06900	ELECTROCARDIOLOGY	18,065	0	2,778			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,017	0	494			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	113	0	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	21,122	0	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	85,170	0	0			73.00
74.00	07400	RENAL DIALYSIS	630	0	405			74.00
76.00	03950	ANCILLARY - OTHER	0	0	0			76.00
76.97	07697	CARDIAC REHABILITATION	922	0	679			76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	42,108	19,358	16,040			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	PATIENT CARE CENTER - OCC	3,958	0	3,444			93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	4,991	0	1,185			96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,879	0	2,829			116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	596,542	59,685	193,203	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
194.00	07950	RENTAL SPACE	0	0	0			194.00
194.01	07951	FOUNDATION	0	0	79			194.01
194.02	07952	RETAIL SERVICES	0	0	161			194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0			194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	0	81,317			194.04
194.05	07955	OTHER NRCC	0	0	23,775			194.05
194.06	07956	VACANT SPACE	0	0	0			194.06
194.08	07958	CAMBRIDGE RHC	0	0	3,334			194.08
200.00		Cross Foot Adjustments				859	13,579	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	596,542	59,685	301,869	859	13,579	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/25/2017 3:15 pm

		Cost Center Description	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
17.01	01701	INSERVICE EDUCATION						17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD						22.00
23.00	02300	PARAMED ED PRGM	214,110					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		1,522,897	0	1,522,897		30.00
31.00	03100	INTENSIVE CARE UNIT		596,074	0	596,074		31.00
40.00	04000	SUBPROVIDER - IPF		236,779	0	236,779		40.00
41.00	04100	SUBPROVIDER - IRF		170,152	0	170,152		41.00
43.00	04300	NURSERY		40,108	0	40,108		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		2,632,721	0	2,632,721		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		143,019	0	143,019		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		1,846,009	0	1,846,009		54.00
59.00	05900	CARDIAC CATHETERIZATION		716,780	0	716,780		59.00
60.00	06000	LABORATORY		803,234	0	803,234		60.00
65.00	06500	RESPIRATORY THERAPY		127,741	0	127,741		65.00
66.00	06600	PHYSICAL THERAPY		3,296,977	0	3,296,977		66.00
69.00	06900	ELECTROCARDIOLOGY		286,270	0	286,270		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		339,240	0	339,240		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		582	0	582		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		80,766	0	80,766		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		619,581	0	619,581		73.00
74.00	07400	RENAL DIALYSIS		14,590	0	14,590		74.00
76.00	03950	ANCILLARY - OTHER		0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION		39,697	0	39,697		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY		534,244	0	534,244		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	04040	PATIENT CARE CENTER - OCC		182,219	0	182,219		93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		303,134	0	303,134		96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE		43,948	0	43,948		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	14,576,762	0	14,576,762		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		279,868	0	279,868		192.00
194.00	07950	RENTAL SPACE		1,563,804	0	1,563,804		194.00
194.01	07951	FOUNDATION		12,178	0	12,178		194.01
194.02	07952	RETAIL SERVICES		62,120	0	62,120		194.02
194.03	07953	REID CONTRACTED SERVICES		1,013	0	1,013		194.03
194.04	07954	REID PHYSICIAN ASSOC.		12,959,610	0	12,959,610		194.04
194.05	07955	OTHER NRCC		24,976	0	24,976		194.05
194.06	07956	VACANT SPACE		1,214,656	0	1,214,656		194.06
194.08	07958	CAMBRIDGE RHC		39,632	0	39,632		194.08
200.00		Cross Foot Adjustments	214,110	228,548	0	228,548		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	214,110	30,963,167	0	30,963,167		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/25/2017 3:15 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW CAP BLDG & FIXT - OFFSITE (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	
			1.00	1.01	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	735,942					1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE	0	275,456				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,669	400	0	152,468,514		4.00
5.01	00540	NONPATIENT TELEPHONES	3,798	0	0	243,262	2,933	5.01
5.02	00550	DATA PROCESSING	12,518	1,095	0	3,904,861	241	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	15,650	0	0	882,963	32	5.03
5.04	00570	ADMITTING	144	1,884	0	1,846,331	90	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	815	8,160	0	2,098,759	141	5.05
5.06	00590	OTHER A&G	25,088	7,055	0	6,560,962	118	5.06
7.00	00700	OPERATION OF PLANT	182,168	4,158	0	2,159,339	58	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,335	0	0	317,181	6	8.00
9.00	00900	HOUSEKEEPING	6,776	0	0	1,474,789	6	9.00
10.00	01000	DIETARY	12,568	0	0	454,501	88	10.00
11.00	01100	CAFETERIA	9,873	0	0	1,992,897	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,955	0	0	402,656	18	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,411	0	0	588,438	10	14.00
15.00	01500	PHARMACY	7,271	0	0	3,808,036	43	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,507	5,883	0	2,107,005	68	16.00
17.00	01700	SOCIAL SERVICE	1,241	0	0	2,148,342	34	17.00
17.01	01701	INSERVICE EDUCATION	10,409	0	0	899,005	46	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	314,039	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	38,332	0	22.00
23.00	02300	PARAMED ED PRGM	1,061	2,680	0	210,364	3	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	109,246	0	0	15,350,822	228	30.00
31.00	03100	INTENSIVE CARE UNIT	24,552	0	0	3,052,332	52	31.00
40.00	04000	SUBPROVIDER - IPF	22,340	0	0	3,235,157	22	40.00
41.00	04100	SUBPROVIDER - IRF	17,898	0	0	1,199,857	32	41.00
43.00	04300	NURSERY	2,681	0	0	375,865	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	48,466	13,091	0	1,655,346	189	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,316	0	0	505,975	43	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	60,780	1,600	0	5,451,506	153	54.00
59.00	05900	CARDIAC CATHETERIZATION	13,579	0	0	1,512,286	29	59.00
60.00	06000	LABORATORY	13,945	0	0	3,380,403	64	60.00
65.00	06500	RESPIRATORY THERAPY	1,647	0	0	1,354,264	6	65.00
66.00	06600	PHYSICAL THERAPY	8,084	42,316	0	4,773,665	90	66.00
69.00	06900	ELECTROCARDIOLOGY	7,011	0	0	843,272	9	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,892	0	271,168	7	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,490	0	0	0	5	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	4,523	0	0	185,409	12	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	22,772	0	0	4,540,138	82	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	PATIENT CARE CENTER - OCC	8,935	847	0	1,188,146	57	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,774	2,872	0	892,767	25	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	445	0	0	1,052,772	13	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	696,741	95,933	0	83,273,212	2,120	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	249	2,456	0	0	65	192.00
194.00	07950	RENTAL SPACE	0	19,030	0	0	97	194.00
194.01	07951	FOUNDATION	206	0	0	154,627	7	194.01
194.02	07952	RETAIL SERVICES	2,340	0	0	104,987	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	223,291	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	34,489	140,869	0	67,731,467	644	194.04
194.05	07955	OTHER NRCC	532	0	0	0	0	194.05
194.06	07956	VACANT SPACE	1,385	17,168	0	0	0	194.06
194.08	07958	CAMBRIDGE RHC	0	0	0	980,930	0	194.08
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/25/2017 3:15 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW CAP BLDG & FIXT - OFFSITE (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	
		1.00	1.01	2.00	4.00	5.01	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	891,634	19,031,190	0	19,560,662	299,545	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.211555	69.089764	0.000000	0.128293	102.129219	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				45,204	5,161	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)				0.000296	1.759632	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/25/2017 3:15 pm

		Cost Center Description	DATA PROCESSING (TERMINALS)	PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	ADMITTING (TOTAL REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (TOTAL REVENUE)	Reconciliation	
			5.02	5.03	5.04	5.05	5A.06	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	2,283					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	238	9,468,865				5.03
5.04	00570	ADMITTING	35	9,795	733,037,489			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	15	14,410	0	733,037,489		5.05
5.06	00590	OTHER A&G	28	61,112	0	0	-13,909,499	5.06
7.00	00700	OPERATION OF PLANT	0	94,018	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2	2,673	0	0	0	8.00
9.00	00900	HOUSEKEEPING	3	141,160	0	0	0	9.00
10.00	01000	DIETARY	34	94,119	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	14	3,505	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12	891,729	0	0	0	14.00
15.00	01500	PHARMACY	40	724,731	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	84	9,352	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	28	6,641	0	0	0	17.00
17.01	01701	INSERVICE EDUCATION	148	13,129	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	2,681	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	10	2,504	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	238	614,761	42,561,081	42,561,081	0	30.00
31.00	03100	INTENSIVE CARE UNIT	35	354,971	8,067,312	8,067,312	0	31.00
40.00	04000	SUBPROVIDER - IPF	15	96,698	10,935,900	10,935,900	0	40.00
41.00	04100	SUBPROVIDER - IRF	28	58,510	3,621,102	3,621,102	0	41.00
43.00	04300	NURSERY	0	48,188	2,064,024	2,064,024	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	87	1,417,628	139,739,616	139,739,616	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	32	108,781	6,179,408	6,179,408	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	152	991,682	113,713,552	113,713,552	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	10	1,153,503	73,418,812	73,418,812	0	59.00
60.00	06000	LABORATORY	58	93,897	75,126,867	75,126,867	0	60.00
65.00	06500	RESPIRATORY THERAPY	12	252,512	14,889,333	14,889,333	0	65.00
66.00	06600	PHYSICAL THERAPY	104	46,006	16,706,624	16,706,624	0	66.00
69.00	06900	ELECTROCARDIOLOGY	49	117,810	22,193,021	22,193,021	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8	8,398	3,706,273	3,706,273	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	139,307	139,307	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	25,948,285	25,948,285	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	104,630,900	104,630,900	0	73.00
74.00	07400	RENAL DIALYSIS	2	13,734	774,296	774,296	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2	6,659	1,133,033	1,133,033	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	75	324,447	51,729,372	51,729,372	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	PATIENT CARE CENTER - OCC	39	65,346	4,862,916	4,862,916	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	12	315,021	6,131,063	6,131,063	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3	269,410	4,765,392	4,765,392	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,652	8,429,521	733,037,489	733,037,489	-13,909,499	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	1	4,808	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	38,475	0	0	0	194.00
194.01	07951	FOUNDATION	6	257	0	0	0	194.01
194.02	07952	RETAIL SERVICES	36	1,522	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	588	970,020	0	0	0	194.04
194.05	07955	OTHER NRCC	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.08	07958	CAMBRIDGE RHC	0	24,262	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/25/2017 3:15 pm

		Cost Center Description	DATA PROCESSING (TERMINALS)	PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	ADMITTING (TOTAL REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (TOTAL REVENUE)	Reconciliation	
			5.02	5.03	5.04	5.05	5A.06	
202.00		Cost to be allocated (per Wkst. B, Part I)	23,394,318	3,834,869	3,799,256	7,019,846		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10,247.182654	0.404998	0.005183	0.009576		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,636,546	412,558	213,287	647,594		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1,592.880420	0.043570	0.000291	0.000883		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/25/2017 3:15 pm

		Cost Center Description	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			5.06	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G	354,734,592					5.06
7.00	00700	OPERATION OF PLANT	5,844,403	621,066				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	758,796	12,335	1,931,816			8.00
9.00	00900	HOUSEKEEPING	2,323,566	6,490	0	14,422		9.00
10.00	01000	DIETARY	913,432	11,035	0	251	51,326	10.00
11.00	01100	CAFETERIA	1,751,867	9,873	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	720,848	1,955	0	600	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,088,275	8,411	49,171	20	0	14.00
15.00	01500	PHARMACY	33,027,372	7,040	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,253,117	1,162	0	89	0	16.00
17.00	01700	SOCIAL SERVICE	3,268,848	438	0	55	0	17.00
17.01	01701	INSERVICE EDUCATION	2,782,321	9,322	0	140	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	376,104	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	118,509	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	524,431	2,807	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,527,577	108,140	517,272	4,244	30,488	30.00
31.00	03100	INTENSIVE CARE UNIT	6,377,400	24,552	126,204	943	4,709	31.00
40.00	04000	SUBPROVIDER - IPF	4,455,437	22,340	112,029	658	10,560	40.00
41.00	04100	SUBPROVIDER - IRF	1,954,572	17,898	62,964	480	3,543	41.00
43.00	04300	NURSERY	577,532	2,681	84,375	18	2,026	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,197,810	40,624	349,465	1,212	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,277,368	8,316	0	311	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,802,793	43,920	123,835	701	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	7,267,228	4,593	0	186	0	59.00
60.00	06000	LABORATORY	12,170,222	13,574	98,769	717	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,467,736	1,194	0	123	0	65.00
66.00	06600	PHYSICAL THERAPY	10,532,608	48,220	15,067	112	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,428,919	557	0	249	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	808,492	5,400	4,578	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,056	0	0	109	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	15,937,238	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,544,247	0	0	143	0	73.00
74.00	07400	RENAL DIALYSIS	695,869	1,490	0	179	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	305,945	0	0	53	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,853,845	22,772	233,321	1,467	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	PATIENT CARE CENTER - OCC	2,110,896	405	20,462	181	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	2,653,916	3,752	0	10	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,477,361	0	0	114	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	213,178,956	441,296	1,797,512	13,365	51,326	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	3,112,977	2,456	109,115	0	0	192.00
194.00	07950	RENTAL SPACE	3,210,769	22,420	0	0	0	194.00
194.01	07951	FOUNDATION	399,135	206	0	20	0	194.01
194.02	07952	RETAIL SERVICES	504,560	684	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	368,012	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	131,347,002	129,804	25,189	1,037	0	194.04
194.05	07955	OTHER NRCC	645	532	0	0	0	194.05
194.06	07956	VACANT SPACE	1,187,811	23,668	0	0	0	194.06
194.08	07958	CAMBRIDGE RHC	1,424,725	0	0	0	0	194.08
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)	13,909,499	6,073,568	909,176	2,478,142	1,100,292	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/25/2017 3:15 pm

	Cost Center Description	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.06	7.00	8.00	9.00	10.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	0.039211	9.779263	0.470633	171.830675	21.437322	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	649,531	647,361	138,169	39,865	286,075	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.001831	1.042338	0.071523	2.764180	5.573686	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/25/2017 3:15 pm

		Cost Center Description	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (MED SUPPLIES)	PHARMACY (DRUGS)	MEDICAL RECORDS & LIBRARY (TOTAL REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
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	3,780,745					11.00
13.00	01300	NURSING ADMINISTRATION	6,808	1,474,148				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	40,998	0	20,399,326			14.00
15.00	01500	PHARMACY	121,714	0	23,975	29,749,872		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	125,540	0	0	7	733,037,489	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	INSERVICE EDUCATION	33,974	0	672	17	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	11,186	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	2,386	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	5,589	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	539,189	539,189	12,264	3,812	42,561,081	30.00
31.00	03100	INTENSIVE CARE UNIT	104,296	104,296	18,487	4,840	8,067,312	31.00
40.00	04000	SUBPROVIDER - IPF	134,302	134,302	0	763	10,935,900	40.00
41.00	04100	SUBPROVIDER - IRF	42,922	42,922	0	500	3,621,102	41.00
43.00	04300	NURSERY	10,753	10,753	94	0	2,064,024	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	175,257	175,257	9,802,251	89,694	139,739,616	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,449	14,449	5,835	27	6,179,408	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	185,031	185,031	17,650	510,195	113,713,552	54.00
59.00	05900	CARDIAC CATHETERIZATION	48,778	48,778	7,465,927	40	73,418,812	59.00
60.00	06000	LABORATORY	149,082	0	1,181,267	65	75,126,867	60.00
65.00	06500	RESPIRATORY THERAPY	47,641	47,641	6,441	29,723	14,889,333	65.00
66.00	06600	PHYSICAL THERAPY	160,609	0	1,459	0	16,706,624	66.00
69.00	06900	ELECTROCARDIOLOGY	29,574	0	8	226,362	22,193,021	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,816	0	0	0	3,706,273	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	139,307	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	25,948,285	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,451,519	104,630,900	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	774,296	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	7,651	7,651	0	0	1,133,033	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	163,879	163,879	1,294	18,307	51,729,372	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	PATIENT CARE CENTER - OCC	49,414	0	0	12,002	4,862,916	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	49,165	0	1,165,166	0	6,131,063	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	40,010	0	1,176	111,524	4,765,392	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,310,013	1,474,148	19,703,966	27,459,397	733,037,489	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	2	0	0	0	0	192.00
194.00	07950	RENTAL SPACE	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	7,466	0	0	0	0	194.01
194.02	07952	RETAIL SERVICES	6,626	0	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	15,376	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	1,415,289	0	695,360	2,241,904	0	194.04
194.05	07955	OTHER NRCC	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.08	07958	CAMBRIDGE RHC	25,973	0	0	48,571	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/25/2017 3:15 pm

		Cost Center Description	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (MED SUPPLIES)	PHARMACY (DRUGS)	MEDICAL RECORDS & LIBRARY (TOTAL REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	1,917,110	874,781	4,378,200	34,458,118	5,549,420	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.507072	0.593415	0.214625	1.158261	0.007570	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	26,051	32,574	430,315	459,273	596,542	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006890	0.022097	0.021095	0.015438	0.000814	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/25/2017 3:15 pm

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INSERVICE EDUCATION (IN HOUSE ED)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)	PARAMED ED PRGM (TIME SPENT)	
			17.00	17.01	21.00	22.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER A&G						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	6,040					17.00
17.01	01701	INSERVICE EDUCATION	0	137,011				17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	439			21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0		439		22.00
23.00	02300	PARAMED ED PRGM	0	892			100	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,272	30,563	287	287	0	30.00
31.00	03100	INTENSIVE CARE UNIT	777	7,651	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	6,496	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	1,881	0	0	0	41.00
43.00	04300	NURSERY	0	403	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,983	47	47	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	32	665	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,152	4	4	100	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,995	0	0	0	59.00
60.00	06000	LABORATORY	0	5,582	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,725	34	34	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,060	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,261	24	24	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	224	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	184	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	308	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,959	7,280	43	43	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	PATIENT CARE CENTER - OCC	0	1,563	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	538	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,284	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,040	87,690	439	439	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
194.00	07950	RENTAL SPACE	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	36	0	0	0	194.01
194.02	07952	RETAIL SERVICES	0	73	0	0	0	194.02
194.03	07953	REID CONTRACTED SERVICES	0	0	0	0	0	194.03
194.04	07954	REID PHYSICIAN ASSOC.	0	36,908	0	0	0	194.04
194.05	07955	OTHER NRCC	0	10,791	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
194.08	07958	CAMBRIDGE RHC	0	1,513	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/25/2017 3:15 pm

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INSERVICE EDUCATION (IN HOUSE ED)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)	PARAMED ED PRGM (TIME SPENT)	
			17.00	17.01	21.00	22.00	23.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	3,410,757	3,024,028	396,523	124,366	594,966	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	564.694868	22.071425	903.241458	283.293850	5,949.660000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	59,685	301,869	859	13,579	214,110	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	9.881623	2.203246	1.956720	30.931663	2,141.100000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,578,775		30,578,775	0	30,578,775	30.00
31.00	03100	INTENSIVE CARE UNIT	7,983,001		7,983,001	0	7,983,001	31.00
40.00	04000	SUBPROVIDER - IPF	5,615,619		5,615,619	0	5,615,619	40.00
41.00	04100	SUBPROVIDER - IRF	2,511,049		2,511,049	0	2,511,049	41.00
43.00	04300	NURSERY	749,005		749,005	0	749,005	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,575,960		33,575,960	0	33,575,960	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,558,927		1,558,927	0	1,558,927	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,464,730		19,464,730	0	19,464,730	54.00
59.00	05900	CARDIAC CATHETERIZATION	9,884,973		9,884,973	0	9,884,973	59.00
60.00	06000	LABORATORY	13,970,972		13,970,972	0	13,970,972	60.00
65.00	06500	RESPIRATORY THERAPY	2,858,403	0	2,858,403	0	2,858,403	65.00
66.00	06600	PHYSICAL THERAPY	11,785,469	0	11,785,469	0	11,785,469	66.00
69.00	06900	ELECTROCARDIOLOGY	3,045,409		3,045,409	0	3,045,409	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	933,134		933,134	0	933,134	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,922		21,922	0	21,922	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,758,582		16,758,582	0	16,758,582	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,059,192		33,059,192	0	33,059,192	73.00
74.00	07400	RENAL DIALYSIS	778,406		778,406	0	778,406	74.00
76.00	03950	ANCILLARY - OTHER	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	350,843		350,843	0	350,843	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,606,716		10,606,716	0	10,606,716	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,653,984		2,653,984		2,653,984	92.00
93.00	04040	PATIENT CARE CENTER - OCC	2,348,625		2,348,625	0	2,348,625	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	3,129,679		3,129,679	0	3,129,679	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,808,218		2,808,218		2,808,218	116.00
200.00		Subtotal (see instructions)	217,031,593	0	217,031,593	0	217,031,593	200.00
201.00		Less Observation Beds	2,653,984		2,653,984		2,653,984	201.00
202.00		Total (see instructions)	214,377,609	0	214,377,609	0	214,377,609	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,619,287		38,619,287			30.00
31.00	03100	INTENSIVE CARE UNIT	8,067,312		8,067,312			31.00
40.00	04000	SUBPROVIDER - IPF	10,935,900		10,935,900			40.00
41.00	04100	SUBPROVIDER - IRF	3,621,102		3,621,102			41.00
43.00	04300	NURSERY	2,064,024		2,064,024			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	49,614,340	90,125,276	139,739,616	0.240275	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,259,248	920,160	6,179,408	0.252278	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,255,169	98,458,383	113,713,552	0.171173	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	20,306,596	53,112,216	73,418,812	0.134638	0.000000	59.00
60.00	06000	LABORATORY	25,229,831	49,897,036	75,126,867	0.185965	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	12,316,472	2,572,861	14,889,333	0.191977	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,083,093	10,623,531	16,706,624	0.705437	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	3,070,101	19,122,920	22,193,021	0.137224	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,259	3,699,014	3,706,273	0.251772	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	126,775	12,532	139,307	0.157365	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	14,886,071	11,062,214	25,948,285	0.645845	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,996,003	70,634,897	104,630,900	0.315960	0.000000	73.00
74.00	07400	RENAL DIALYSIS	733,145	41,151	774,296	1.005308	0.000000	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	2,962	1,130,071	1,133,033	0.309649	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,048,168	43,681,204	51,729,372	0.205042	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	727,613	3,214,181	3,941,794	0.673293	0.000000	92.00
93.00	04040	PATIENT CARE CENTER - OCC	122,958	4,739,958	4,862,916	0.482966	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	6,131,063	6,131,063	0.510463	0.000000	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,683,584	3,081,808	4,765,392			116.00
200.00		Subtotal (see instructions)	260,777,013	472,260,476	733,037,489			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	260,777,013	472,260,476	733,037,489			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.240275	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.252278	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171173	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.134638	59.00
60.00	06000	LABORATORY	0.185965	60.00
65.00	06500	RESPIRATORY THERAPY	0.191977	65.00
66.00	06600	PHYSICAL THERAPY	0.705437	66.00
69.00	06900	ELECTROCARDIOLOGY	0.137224	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.251772	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.157365	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.645845	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.315960	73.00
74.00	07400	RENAL DIALYSIS	1.005308	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.309649	76.97
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.205042	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.673293	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0.482966	93.00
		OTHER REIMBURSABLE COST CENTERS		
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.510463	96.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/25/2017 3:15 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,578,775		30,578,775	0	30,578,775	30.00
31.00	03100	INTENSIVE CARE UNIT	7,983,001		7,983,001	0	7,983,001	31.00
40.00	04000	SUBPROVIDER - IPF	5,615,619		5,615,619	0	5,615,619	40.00
41.00	04100	SUBPROVIDER - IRF	2,511,049		2,511,049	0	2,511,049	41.00
43.00	04300	NURSERY	749,005		749,005	0	749,005	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,575,960		33,575,960	0	33,575,960	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,558,927		1,558,927	0	1,558,927	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,464,730		19,464,730	0	19,464,730	54.00
59.00	05900	CARDIAC CATHETERIZATION	9,884,973		9,884,973	0	9,884,973	59.00
60.00	06000	LABORATORY	13,970,972		13,970,972	0	13,970,972	60.00
65.00	06500	RESPIRATORY THERAPY	2,858,403	0	2,858,403	0	2,858,403	65.00
66.00	06600	PHYSICAL THERAPY	11,785,469	0	11,785,469	0	11,785,469	66.00
69.00	06900	ELECTROCARDIOLOGY	3,045,409		3,045,409	0	3,045,409	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	933,134		933,134	0	933,134	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,922		21,922	0	21,922	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,758,582		16,758,582	0	16,758,582	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,059,192		33,059,192	0	33,059,192	73.00
74.00	07400	RENAL DIALYSIS	778,406		778,406	0	778,406	74.00
76.00	03950	ANCILLARY - OTHER	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	350,843		350,843	0	350,843	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,606,716		10,606,716	0	10,606,716	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,653,984		2,653,984		2,653,984	92.00
93.00	04040	PATIENT CARE CENTER - OCC	2,348,625		2,348,625	0	2,348,625	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	3,129,679		3,129,679	0	3,129,679	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,808,218		2,808,218		2,808,218	116.00
200.00		Subtotal (see instructions)	217,031,593	0	217,031,593	0	217,031,593	200.00
201.00		Less Observation Beds	2,653,984		2,653,984		2,653,984	201.00
202.00		Total (see instructions)	214,377,609	0	214,377,609	0	214,377,609	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/25/2017 3:15 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,619,287		38,619,287			30.00
31.00	03100	INTENSIVE CARE UNIT	8,067,312		8,067,312			31.00
40.00	04000	SUBPROVIDER - IPF	10,935,900		10,935,900			40.00
41.00	04100	SUBPROVIDER - IRF	3,621,102		3,621,102			41.00
43.00	04300	NURSERY	2,064,024		2,064,024			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	49,614,340	90,125,276	139,739,616	0.240275	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,259,248	920,160	6,179,408	0.252278	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,255,169	98,458,383	113,713,552	0.171173	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	20,306,596	53,112,216	73,418,812	0.134638	0.000000	59.00
60.00	06000	LABORATORY	25,229,831	49,897,036	75,126,867	0.185965	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	12,316,472	2,572,861	14,889,333	0.191977	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,083,093	10,623,531	16,706,624	0.705437	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	3,070,101	19,122,920	22,193,021	0.137224	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,259	3,699,014	3,706,273	0.251772	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	126,775	12,532	139,307	0.157365	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	14,886,071	11,062,214	25,948,285	0.645845	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,996,003	70,634,897	104,630,900	0.315960	0.000000	73.00
74.00	07400	RENAL DIALYSIS	733,145	41,151	774,296	1.005308	0.000000	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	2,962	1,130,071	1,133,033	0.309649	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,048,168	43,681,204	51,729,372	0.205042	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	727,613	3,214,181	3,941,794	0.673293	0.000000	92.00
93.00	04040	PATIENT CARE CENTER - OCC	122,958	4,739,958	4,862,916	0.482966	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	6,131,063	6,131,063	0.510463	0.000000	96.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,683,584	3,081,808	4,765,392			116.00
200.00		Subtotal (see instructions)	260,777,013	472,260,476	733,037,489			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	260,777,013	472,260,476	733,037,489			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/25/2017 3:15 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
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
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03950	ANCILLARY - OTHER	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040	PATIENT CARE CENTER - OCC	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
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: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part I Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,522,897	0	1,522,897	32,653	46.64	30.00
31.00	INTENSIVE CARE UNIT	596,074		596,074	4,709	126.58	31.00
40.00	SUBPROVIDER - IPF	236,779	0	236,779	10,560	22.42	40.00
41.00	SUBPROVIDER - IRF	170,152	0	170,152	3,517	48.38	41.00
43.00	NURSERY	40,108		40,108	2,026	19.80	43.00
200.00	Total (lines 30-199)	2,566,010		2,566,010	53,465		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	18,255	851,413				30.00
31.00	INTENSIVE CARE UNIT	2,007	254,046				31.00
40.00	SUBPROVIDER - IPF	7,681	172,208				40.00
41.00	SUBPROVIDER - IRF	2,326	112,532				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30-199)	30,269	1,390,199				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,632,721	139,739,616	0.018840	35,472,156	668,295	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	143,019	6,179,408	0.023144	49,344	1,142	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,846,009	113,713,552	0.016234	13,657,158	221,710	54.00
59.00	05900	CARDIAC CATHETERIZATION	716,780	73,418,812	0.009763	12,948,074	126,412	59.00
60.00	06000	LABORATORY	803,234	75,126,867	0.010692	16,870,983	180,385	60.00
65.00	06500	RESPIRATORY THERAPY	127,741	14,889,333	0.008579	8,541,537	73,278	65.00
66.00	06600	PHYSICAL THERAPY	3,296,977	16,706,624	0.197345	2,120,648	418,499	66.00
69.00	06900	ELECTROCARDIOLOGY	286,270	22,193,021	0.012899	2,404,361	31,014	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	339,240	3,706,273	0.091531	7,259	664	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	582	139,307	0.004178	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	80,766	25,948,285	0.003113	9,463,070	29,459	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	619,581	104,630,900	0.005922	20,244,061	119,885	73.00
74.00	07400	RENAL DIALYSIS	14,590	774,296	0.018843	546,573	10,299	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	39,697	1,133,033	0.035036	2,962	104	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	534,244	51,729,372	0.010328	7,214,588	74,512	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	132,174	3,941,794	0.033531	727,613	24,398	92.00
93.00	04040	PATIENT CARE CENTER - OCC	182,219	4,862,916	0.037471	121,082	4,537	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	303,134	6,131,063	0.049442	0	0	96.00
200.00		Total (lines 50-199)	12,098,978	664,964,472		130,391,469	1,984,593	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0		0	43.00
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	32,653	0.00	18,255	0		30.00
31.00	03100	INTENSIVE CARE UNIT	4,709	0.00	2,007	0		31.00
40.00	04000	SUBPROVIDER - IPF	10,560	0.00	7,681	0		40.00
41.00	04100	SUBPROVIDER - IRF	3,517	0.00	2,326	0		41.00
43.00	04300	NURSERY	2,026	0.00	0	0		43.00
200.00		Total (lines 30-199)	53,465		30,269	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	594,966	0	594,966	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	594,966	0	594,966	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	139,739,616	0.000000	0.000000	35,472,156	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,179,408	0.000000	0.000000	49,344	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	594,966	113,713,552	0.005232	0.005232	13,657,158	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	73,418,812	0.000000	0.000000	12,948,074	59.00
60.00	06000	LABORATORY	0	75,126,867	0.000000	0.000000	16,870,983	60.00
65.00	06500	RESPIRATORY THERAPY	0	14,889,333	0.000000	0.000000	8,541,537	65.00
66.00	06600	PHYSICAL THERAPY	0	16,706,624	0.000000	0.000000	2,120,648	66.00
69.00	06900	ELECTROCARDIOLOGY	0	22,193,021	0.000000	0.000000	2,404,361	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,706,273	0.000000	0.000000	7,259	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	139,307	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	25,948,285	0.000000	0.000000	9,463,070	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	104,630,900	0.000000	0.000000	20,244,061	73.00
74.00	07400	RENAL DIALYSIS	0	774,296	0.000000	0.000000	546,573	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,133,033	0.000000	0.000000	2,962	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	51,729,372	0.000000	0.000000	7,214,588	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,941,794	0.000000	0.000000	727,613	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0	4,862,916	0.000000	0.000000	121,082	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	6,131,063	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	594,966	664,964,472			130,391,469	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	30,909,376	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	470	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	71,454	37,570,384	196,568		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	26,419,220	0		59.00
60.00	06000	LABORATORY	0	8,525,522	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	854,093	0		65.00
66.00	06600	PHYSICAL THERAPY	0	35,571	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	10,507,096	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,632,728	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	5,186,083	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,334,989	0		73.00
74.00	07400	RENAL DIALYSIS	0	25,007	0		74.00
76.00	03950	ANCILLARY - OTHER	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	554,944	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	11,810,558	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	931,965	0		92.00
93.00	04040	PATIENT CARE CENTER - OCC	0	3,048,922	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00		Total (lines 50-199)	71,454	159,346,928	196,568		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.240275	30,909,376	0	0	7,426,750	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.252278	470	0	0	119	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171173	37,570,384	0	0	6,431,035	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.134638	26,419,220	0	0	3,557,031	59.00
60.00	06000	LABORATORY	0.185965	8,525,522	2,470	0	1,585,449	60.00
65.00	06500	RESPIRATORY THERAPY	0.191977	854,093	0	0	163,966	65.00
66.00	06600	PHYSICAL THERAPY	0.705437	35,571	0	0	25,093	66.00
69.00	06900	ELECTROCARDIOLOGY	0.137224	10,507,096	0	0	1,441,826	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.251772	1,632,728	0	0	411,075	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.157365	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.645845	5,186,083	0	0	3,349,406	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.315960	21,334,989	645	87,000	6,741,003	73.00
74.00	07400	RENAL DIALYSIS	1.005308	25,007	0	0	25,140	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.309649	554,944	0	0	171,838	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.205042	11,810,558	0	0	2,421,660	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.673293	931,965	0	0	627,486	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0.482966	3,048,922	0	0	1,472,526	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.510463	0	0	0	0	96.00
200.00		Subtotal (see instructions)		159,346,928	3,115	87,000	35,851,403	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		159,346,928	3,115	87,000	35,851,403	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	459	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	204	27,489	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	663	27,489	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	663	27,489	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Subprovider - IPF | 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	2,632,721	139,739,616	0.018840	22,059	416	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	143,019	6,179,408	0.023144	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,846,009	113,713,552	0.016234	428,014	6,948	54.00
59.00	05900	CARDIAC CATHETERIZATION	716,780	73,418,812	0.009763	13,767	134	59.00
60.00	06000	LABORATORY	803,234	75,126,867	0.010692	720,976	7,709	60.00
65.00	06500	RESPIRATORY THERAPY	127,741	14,889,333	0.008579	397,292	3,408	65.00
66.00	06600	PHYSICAL THERAPY	3,296,977	16,706,624	0.197345	301,938	59,586	66.00
69.00	06900	ELECTROCARDIOLOGY	286,270	22,193,021	0.012899	33,180	428	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	339,240	3,706,273	0.091531	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	582	139,307	0.004178	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	80,766	25,948,285	0.003113	5,260	16	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	619,581	104,630,900	0.005922	1,358,385	8,044	73.00
74.00	07400	RENAL DIALYSIS	14,590	774,296	0.018843	5,747	108	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	39,697	1,133,033	0.035036	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	534,244	51,729,372	0.010328	534,837	5,524	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,941,794	0.000000	0	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	182,219	4,862,916	0.037471	1,564	59	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	303,134	6,131,063	0.049442	0	0	96.00
200.00		Total (lines 50-199)	11,966,804	664,964,472		3,823,019	92,380	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	594,966	0	594,966	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	594,966	0	594,966	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Subprovider - IPF | 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	139,739,616	0.000000	0.000000	22,059	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,179,408	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	594,966	113,713,552	0.005232	0.005232	428,014	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	73,418,812	0.000000	0.000000	13,767	59.00
60.00	06000	LABORATORY	0	75,126,867	0.000000	0.000000	720,976	60.00
65.00	06500	RESPIRATORY THERAPY	0	14,889,333	0.000000	0.000000	397,292	65.00
66.00	06600	PHYSICAL THERAPY	0	16,706,624	0.000000	0.000000	301,938	66.00
69.00	06900	ELECTROCARDIOLOGY	0	22,193,021	0.000000	0.000000	33,180	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,706,273	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	139,307	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	25,948,285	0.000000	0.000000	5,260	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	104,630,900	0.000000	0.000000	1,358,385	73.00
74.00	07400	RENAL DIALYSIS	0	774,296	0.000000	0.000000	5,747	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,133,033	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	51,729,372	0.000000	0.000000	534,837	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,941,794	0.000000	0.000000	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0	4,862,916	0.000000	0.000000	1,564	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	6,131,063	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	594,966	664,964,472			3,823,019	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/25/2017 3:15 pm
	Title XVIII	Subprovider - IPF	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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,239	0	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	64	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	105	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03950	ANCILLARY - OTHER	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	4,718	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	PATIENT CARE CENTER - OCC	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00		Total (lines 50-199)	2,239	4,887	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V | Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Subprovider - IPF | 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	0.240275	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.252278	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171173	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.134638	0	0	0	0	59.00
60.00	06000	LABORATORY	0.185965	64	0	0	12	60.00
65.00	06500	RESPIRATORY THERAPY	0.191977	105	0	0	20	65.00
66.00	06600	PHYSICAL THERAPY	0.705437	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.137224	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.251772	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.157365	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.645845	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.315960	0	0	5,427	0	73.00
74.00	07400	RENAL DIALYSIS	1.005308	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.309649	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.205042	4,718	0	0	967	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.673293	0	0	0	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0.482966	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.510463	0	0	0	0	96.00
200.00		Subtotal (see instructions)		4,887	0	5,427	999	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		4,887	0	5,427	999	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V | Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,715		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY - OTHER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	PATIENT CARE CENTER - OCC	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	1,715		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	1,715		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,632,721	139,739,616	0.018840	3,181	60	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	143,019	6,179,408	0.023144	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,846,009	113,713,552	0.016234	71,129	1,155	54.00
59.00	05900	CARDIAC CATHETERIZATION	716,780	73,418,812	0.009763	488	5	59.00
60.00	06000	LABORATORY	803,234	75,126,867	0.010692	196,883	2,105	60.00
65.00	06500	RESPIRATORY THERAPY	127,741	14,889,333	0.008579	175,216	1,503	65.00
66.00	06600	PHYSICAL THERAPY	3,296,977	16,706,624	0.197345	1,747,290	344,819	66.00
69.00	06900	ELECTROCARDIOLOGY	286,270	22,193,021	0.012899	2,051	26	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	339,240	3,706,273	0.091531	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	582	139,307	0.004178	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	80,766	25,948,285	0.003113	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	619,581	104,630,900	0.005922	389,614	2,307	73.00
74.00	07400	RENAL DIALYSIS	14,590	774,296	0.018843	16,195	305	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	39,697	1,133,033	0.035036	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	534,244	51,729,372	0.010328	1,851	19	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,941,794	0.000000	0	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	182,219	4,862,916	0.037471	312	12	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	303,134	6,131,063	0.049442	0	0	96.00
200.00		Total (lines 50-199)	11,966,804	664,964,472		2,604,210	352,316	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	594,966	0	594,966	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	594,966	0	594,966	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/25/2017 3:15 pm

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		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	139,739,616	0.000000	0.000000	3,181	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,179,408	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	594,966	113,713,552	0.005232	0.005232	71,129	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	73,418,812	0.000000	0.000000	488	59.00
60.00	06000	LABORATORY	0	75,126,867	0.000000	0.000000	196,883	60.00
65.00	06500	RESPIRATORY THERAPY	0	14,889,333	0.000000	0.000000	175,216	65.00
66.00	06600	PHYSICAL THERAPY	0	16,706,624	0.000000	0.000000	1,747,290	66.00
69.00	06900	ELECTROCARDIOLOGY	0	22,193,021	0.000000	0.000000	2,051	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,706,273	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	139,307	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	25,948,285	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	104,630,900	0.000000	0.000000	389,614	73.00
74.00	07400	RENAL DIALYSIS	0	774,296	0.000000	0.000000	16,195	74.00
76.00	03950	ANCILLARY - OTHER	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,133,033	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	51,729,372	0.000000	0.000000	1,851	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,941,794	0.000000	0.000000	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0	4,862,916	0.000000	0.000000	312	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	6,131,063	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	594,966	664,964,472			2,604,210	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/25/2017 3:15 pm

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		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	372	0	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03950	ANCILLARY - OTHER	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	160	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	PATIENT CARE CENTER - OCC	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00		Total (lines 50-199)	372	160	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V | Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.240275	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.252278	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171173	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.134638	0	0	0	0	59.00
60.00	06000	LABORATORY	0.185965	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.191977	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.705437	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.137224	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.251772	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.157365	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.645845	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.315960	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1.005308	0	0	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.309649	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.205042	160	0	187	33	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.673293	0	0	0	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0.482966	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.510463	0	0	0	0	96.00
200.00		Subtotal (see instructions)		160	0	187	33	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		160	0	187	33	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/25/2017 3:15 pm
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	Costs Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY - OTHER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	38		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	PATIENT CARE CENTER - OCC	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	38		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	38		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/25/2017 3:15 pm

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	0.240275	0	2,070,733	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.252278	0	71,135	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171173	0	2,792,207	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.134638	0	883,171	0	0	59.00
60.00	06000	LABORATORY	0.185965	0	1,459,785	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.191977	0	70,549	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.705437	0	610,384	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.137224	0	302,907	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.251772	0	40,664	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.157365	0	63	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.645845	0	210,574	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.315960	0	1,726,228	0	0	73.00
74.00	07400	RENAL DIALYSIS	1.005308	0	522	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.309649	0	9,532	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.205042	0	2,528,019	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.673293	0	274,481	0	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0.482966	0	123,466	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.510463	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	13,174,420	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	13,174,420	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/25/2017 3:15 pm

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	497,545	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,946	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	477,950	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	118,908	0	59.00
60.00	06000	LABORATORY	271,469	0	60.00
65.00	06500	RESPIRATORY THERAPY	13,544	0	65.00
66.00	06600	PHYSICAL THERAPY	430,587	0	66.00
69.00	06900	ELECTROCARDIOLOGY	41,566	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,238	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	135,998	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	545,419	0	73.00
74.00	07400	RENAL DIALYSIS	525	0	74.00
76.00	03950	ANCILLARY - OTHER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,952	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	518,350	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	184,806	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	59,630	0	93.00
		OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	3,327,443	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	3,327,443	0	202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/25/2017 3:15 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	32,653	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	32,653	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)	29,819	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)	18,255	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)	30,578,775	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)	30,578,775	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)	30,578,775	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)	936.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	17,095,442	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)	17,095,442	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	7,983,001	4,709	1,695.26	2,007	3,402,387	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	34,307,549	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	54,805,378	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)	1,105,459	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,056,047	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	3,161,506	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	51,643,872	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,834	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	936.48	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,653,984	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,522,897	30,578,775	0.049802	2,653,984	132,174	90.00
91.00	Nursing School cost	0	30,578,775	0.000000	2,653,984	0	91.00
92.00	Allied health cost	0	30,578,775	0.000000	2,653,984	0	92.00
93.00	All other Medical Education	0	30,578,775	0.000000	2,653,984	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/25/2017 3:15 pm
	Title XVIII	Subprovider - IPF	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)	10,560	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,560	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)	10,560	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)	7,681	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)	5,615,619	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)	5,615,619	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)	5,615,619	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)	531.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,084,602	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)	4,084,602	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,057,105	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,141,707	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)	172,208	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	94,619	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	266,827	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,874,880	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: 15-0048 Component CCN: 15-S048	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/25/2017 3:15 pm
	Title XVIII	Subprovider - IPF	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	236,779	5,615,619	0.042164	0	0	90.00
91.00	Nursing School cost	0	5,615,619	0.000000	0	0	91.00
92.00	Allied health cost	0	5,615,619	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,615,619	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/25/2017 3:15 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,517	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,517	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)	3,517	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,326	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)	2,511,049	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)	2,511,049	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)	2,511,049	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)	713.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,660,694	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)	1,660,694	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,456,053	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,116,747	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)	112,532	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	352,688	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	465,220	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,651,527	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: 15-0048 Component CCN: 15-T048	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/25/2017 3:15 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	170,152	2,511,049	0.067761	0	0	90.00
91.00	Nursing School cost	0	2,511,049	0.000000	0	0	91.00
92.00	Allied health cost	0	2,511,049	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,511,049	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/25/2017 3:15 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	32,653	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	32,653	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)	29,819	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)	713	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)	2,026	15.00
16.00	Nursery days (title V or XIX only)	49	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)	30,578,775	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)	30,578,775	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)	30,578,775	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)	936.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	667,710	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)	667,710	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/25/2017 3:15 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	749,005	2,026	369.70	49	18,115	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	7,983,001	4,709	1,695.26	114	193,260	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,461,403	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,340,488	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,834	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	936.48	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,653,984	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/25/2017 3:15 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,522,897	30,578,775	0.049802	2,653,984	132,174	90.00
91.00	Nursing School cost	0	30,578,775	0.000000	2,653,984	0	91.00
92.00	Allied health cost	0	30,578,775	0.000000	2,653,984	0	92.00
93.00	All other Medical Education	0	30,578,775	0.000000	2,653,984	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/25/2017 3:15 pm
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	10,560	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,560	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)	10,560	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)	0	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)	2,026	15.00
16.00	Nursery days (title V or XIX only)	49	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)	5,615,619	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)	5,615,619	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)	5,615,619	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)	531.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/25/2017 3:15 pm

Title XIX | Subprovider - IPF | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	97	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	97	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/25/2017 3:15 pm
	Title XIX	Subprovider - IPF	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	236,779	5,615,619	0.042164	0	0	90.00
91.00	Nursing School cost	0	5,615,619	0.000000	0	0	91.00
92.00	Allied health cost	0	5,615,619	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,615,619	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/25/2017 3:15 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,517	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,517	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)	3,517	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)	0	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)	2,026	15.00
16.00	Nursery days (title V or XIX only)	49	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)	2,511,049	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)	2,511,049	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)	2,511,049	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)	713.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/25/2017 3:15 pm

Title XIX | Subprovider - IRF | Cost

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

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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/25/2017 3:15 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	170,152	2,511,049	0.067761	0	0	90.00
91.00	Nursing School cost	0	2,511,049	0.000000	0	0	91.00
92.00	Allied health cost	0	2,511,049	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,511,049	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		20,911,564		30.00
31.00	03100	INTENSIVE CARE UNIT		6,124,536		31.00
40.00	04000	SUBPROVIDER - IPF		505,024		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.240275	35,472,156	8,523,072	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.252278	49,344	12,448	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171173	13,657,158	2,337,737	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.134638	12,948,074	1,743,303	59.00
60.00	06000	LABORATORY	0.185965	16,870,983	3,137,412	60.00
65.00	06500	RESPIRATORY THERAPY	0.191977	8,541,537	1,639,779	65.00
66.00	06600	PHYSICAL THERAPY	0.705437	2,120,648	1,495,984	66.00
69.00	06900	ELECTROCARDIOLOGY	0.137224	2,404,361	329,936	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.251772	7,259	1,828	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.157365	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.645845	9,463,070	6,111,676	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.315960	20,244,061	6,396,314	73.00
74.00	07400	RENAL DIALYSIS	1.005308	546,573	549,474	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.309649	2,962	917	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.205042	7,214,588	1,479,294	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.673293	727,613	489,897	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0.482966	121,082	58,478	93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.510463	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		130,391,469	34,307,549	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)		130,391,469		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/25/2017 3:15 pm
	Title XVIII	Subprovider - IPF	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
40.00	04000	SUBPROVIDER - IPF		7,932,491		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.240275	22,059	5,300	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.252278	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171173	428,014	73,264	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.134638	13,767	1,854	59.00
60.00	06000	LABORATORY	0.185965	720,976	134,076	60.00
65.00	06500	RESPIRATORY THERAPY	0.191977	397,292	76,271	65.00
66.00	06600	PHYSICAL THERAPY	0.705437	301,938	212,998	66.00
69.00	06900	ELECTROCARDIOLOGY	0.137224	33,180	4,553	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.251772	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.157365	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.645845	5,260	3,397	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.315960	1,358,385	429,195	73.00
74.00	07400	RENAL DIALYSIS	1.005308	5,747	5,778	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.309649	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.205042	534,837	109,664	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.673293	0	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0.482966	1,564	755	93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.510463	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		3,823,019	1,057,105	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)		3,823,019		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/25/2017 3:15 pm
	Title XVIII	Subprovider - IRF	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		2,397,969		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.240275	3,181	764	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.252278	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171173	71,129	12,175	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.134638	488	66	59.00
60.00	06000	LABORATORY	0.185965	196,883	36,613	60.00
65.00	06500	RESPIRATORY THERAPY	0.191977	175,216	33,637	65.00
66.00	06600	PHYSICAL THERAPY	0.705437	1,747,290	1,232,603	66.00
69.00	06900	ELECTROCARDIOLOGY	0.137224	2,051	281	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.251772	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.157365	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.645845	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.315960	389,614	123,102	73.00
74.00	07400	RENAL DIALYSIS	1.005308	16,195	16,281	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.309649	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.205042	1,851	380	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.673293	0	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0.482966	312	151	93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.510463	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		2,604,210	1,456,053	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)		2,604,210		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/25/2017 3:15 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,539,276		30.00
31.00	03100	INTENSIVE CARE UNIT		319,081		31.00
40.00	04000	SUBPROVIDER - IPF		502,445		40.00
41.00	04100	SUBPROVIDER - IRF		44,273		41.00
43.00	04300	NURSERY		397,119		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.240275	1,041,964	250,358	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.252278	454,796	114,735	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171173	474,016	81,139	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.134638	451,492	60,788	59.00
60.00	06000	LABORATORY	0.185965	955,181	177,630	60.00
65.00	06500	RESPIRATORY THERAPY	0.191977	345,516	66,331	65.00
66.00	06600	PHYSICAL THERAPY	0.705437	126,046	88,918	66.00
69.00	06900	ELECTROCARDIOLOGY	0.137224	91,254	12,522	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.251772	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.157365	7,116	1,120	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.645845	242,172	156,406	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.315960	1,372,838	433,762	73.00
74.00	07400	RENAL DIALYSIS	1.005308	17,223	17,314	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.309649	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.205042	1,851	380	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.673293	0	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0.482966	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.510463	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		5,581,465	1,461,403	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)		5,581,465		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0048 | Component CCN: 15-S048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/25/2017 3:15 pm

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		1,041,489		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.240275	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.252278	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171173	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.134638	0	0	59.00
60.00	06000	LABORATORY	0.185965	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.191977	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.705437	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.137224	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.251772	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.157365	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.645845	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.315960	0	0	73.00
74.00	07400	RENAL DIALYSIS	1.005308	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.309649	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.205042	473	97	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.673293	0	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0.482966	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.510463	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		473	97	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)		473		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/25/2017 3:15 pm
	Title XIX	Subprovider - IRF	Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		277,992		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.240275	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.252278	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171173	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.134638	0	0	59.00
60.00	06000	LABORATORY	0.185965	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.191977	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.705437	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.137224	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.251772	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.157365	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.645845	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.315960	0	0	73.00
74.00	07400	RENAL DIALYSIS	1.005308	0	0	74.00
76.00	03950	ANCILLARY - OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.309649	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.205042	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.673293	0	0	92.00
93.00	04040	PATIENT CARE CENTER - OCC	0.482966	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.510463	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/25/2017 3:15 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	36,227,860	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	12,022,772	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)	571,534	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	6,779,210	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	157.26	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	4.39	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	4.39	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.027916	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.027965	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.027916	21.00
22.00	IME payment adjustment (see instructions)	730,418	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	102,624	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)	730,418	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	102,624	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.90	30.00
31.00	Percentage of Medicaid patient days (see instructions)	20.50	31.00
32.00	Sum of lines 30 and 31	25.40	32.00
33.00	Allowable disproportionate share percentage (see instructions)	10.17	33.00
34.00	Disproportionate share adjustment (see instructions)	1,226,772	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/25/2017 3:15 pm
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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)	0.000227066	0.000215261	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,454,619	1,286,719	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,088,977	324,324	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,413,301		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)	52,192,657		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	64,165,708		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	64,268,332	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	4,029,200	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).	164,067	52.00
53.00	Nursing and Allied Health Managed Care payment	26,422	53.00
54.00	Special add-on payments for new technologies	3,107	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)	71,454	58.00
59.00	Total (sum of amounts on lines 49 through 58)	68,562,582	59.00
60.00	Primary payer payments	21,241	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	68,541,341	61.00
62.00	Deductibles billed to program beneficiaries	5,051,746	62.00
63.00	Coinsurance billed to program beneficiaries	41,216	63.00
64.00	Allowable bad debts (see instructions)	824,696	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	536,052	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	346,510	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	63,984,431	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)	217,798	70.93
70.94	HRR adjustment amount (see instructions)	-272,656	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/25/2017 3:15 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		63,929,573	71.00
71.01	Sequestration adjustment (see instructions)		1,278,591	71.01
72.00	Interim payments		62,484,135	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)		166,847	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/25/2017 3:15 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	28,152	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	35,654,835	2.00
3.00	PPS payments	41,321,371	3.00
4.00	Outlier payment (see instructions)	50,288	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	196,568	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	28,152	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	90,115	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)	90,115	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)	90,115	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	61,963	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)	28,152	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)	41,568,227	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	108	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	7,812,209	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)	33,784,062	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	93,374	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)	33,877,436	30.00
31.00	Primary payer payments	4,850	31.00
32.00	Subtotal (line 30 minus line 31)	33,872,586	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)	1,512,613	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	983,198	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	800,350	36.00
37.00	Subtotal (see instructions)	34,855,784	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-96	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)	34,855,880	40.00
40.01	Sequestration adjustment (see instructions)	697,118	40.01
41.00	Interim payments	33,857,799	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	300,963	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/25/2017 3:15 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,715	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	999	2.00
3.00	PPS payments	1,756	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,715	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	5,427	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)	5,427	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)	5,427	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	3,712	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	1,715	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	1,756	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)	27	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)	3,444	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)	3,444	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	3,444	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	3,444	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)	3,444	40.00
40.01	Sequestration adjustment (see instructions)	69	40.01
41.00	Interim payments	3,298	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	77	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/25/2017 3:15 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	38	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	33	2.00
3.00	PPS payments	55	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	38	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	187	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)	187	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)	187	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	149	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)	38	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)	55	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)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	93	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)	93	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	93	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	93	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)	93	40.00
40.01	Sequestration adjustment (see instructions)	2	40.01
41.00	Interim payments	111	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-20	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: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		62,484,135		33,510,399	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	08/02/2016	347,400	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		347,400	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)		62,484,135		33,857,799	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		166,847		300,963	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		62,650,982		34,158,762	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: 15-0048 Component CCN: 15-S048	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part I Date/Time Prepared: 5/25/2017 3:15 pm
	Title XVIII	Subprovider - IPF	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		6,621,947		3,298	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		6,621,947		3,298	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		138,402		77	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,760,349		3,375	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: 15-0048 | Component CCN: 15-T048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,711,667		111	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,711,667		111	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		78,743		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		20	6.02
7.00	Total Medicare program liability (see instructions)		3,790,410		91	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: 15-0048	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/25/2017 3:15 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	10,232	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	20,262	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	3,042	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	34,528	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	733,037,489	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	10,129,399	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)	653,020	8.00
9.00	Sequestration adjustment amount (see instructions)	13,060	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	639,960	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)	639,960	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part II Date/Time Prepared: 5/25/2017 3:15 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	7,526,320	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	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	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	28.852459	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	7,526,320	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	7,526,320	16.00
17.00	Primary payer payments	2,548	17.00
18.00	Subtotal (line 16 less line 17).	7,523,772	18.00
19.00	Deductibles	360,472	19.00
20.00	Subtotal (line 18 minus line 19)	7,163,300	20.00
21.00	Coinsurance	406,182	21.00
22.00	Subtotal (line 20 minus line 21)	6,757,118	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	213,781	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	138,958	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	164,913	25.00
26.00	Subtotal (sum of lines 22 and 24)	6,896,076	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	2,239	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	6,898,315	31.00
31.01	Sequestration adjustment (see instructions)	137,966	31.01
32.00	Interim payments	6,621,947	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	138,402	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part III Date/Time Prepared: 5/25/2017 3:15 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	3,751,305	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0447	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	137,673	3.00
4.00	Outlier Payments	12,664	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)	9.609290	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)	3,901,642	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)	3,901,642	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	3,901,642	19.00
20.00	Deductibles	19,320	20.00
21.00	Subtotal (line 19 minus line 20)	3,882,322	21.00
22.00	Coinsurance	21,252	22.00
23.00	Subtotal (line 21 minus line 22)	3,861,070	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	9,727	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	6,323	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	4,913	26.00
27.00	Subtotal (sum of lines 23 and 25)	3,867,393	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)	372	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)	3,867,765	32.00
32.01	Sequestration adjustment (see instructions)	77,355	32.01
33.00	Interim payments	3,711,667	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)	78,743	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	12,664	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 5/25/2017 3:15 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	2,340,488		1.00
2.00	Medical and other services		3,327,443	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	2,340,488	3,327,443	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	2,340,488	3,327,443	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	5,581,465	13,174,420	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	5,581,465	13,174,420	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	5,581,465	13,174,420	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	3,240,977	9,846,977	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	2,340,488	3,327,443	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	2,340,488	3,327,443	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	2,340,488	3,327,443	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	2,340,488	3,327,443	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	2,340,488	3,327,443	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	2,340,488	3,327,443	40.00
41.00	Interim payments	2,340,488	3,327,443	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 5/25/2017 3:15 pm
	Title XIX	Subprovider - IPF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	97		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	97	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	97	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	473	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	473	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	473	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	376	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	97	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	97	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	97	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	97	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	97	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	97	0	40.00
41.00	Interim payments	97	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 5/25/2017 3:15 pm
	Title XIX	Subprovider - IRF	Cost

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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-4 | Date/Time Prepared: 5/25/2017 3:15 pm

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	2.44	1.95		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	2.44	1.95		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	2.44	1.95		17.00
18.00	Per resident amount	85,000.00	85,000.00		18.00
19.00	Approved amount for resident costs	207,400	165,750	373,150	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			373,150	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	30,269	3,921		26.00
27.00	Total Inpatient Days (see instructions)	48,754	48,754		27.00
28.00	Ratio of inpatient days to total inpatient days	0.620852	0.080424		28.00
29.00	Program direct GME amount	231,671	30,010		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		4,240		30.00
31.00	Net Program direct GME amount			257,441	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 15-0048	Period: From 01/01/2016 To 12/31/2016	Worksheet E-4 Date/Time Prepared: 5/25/2017 3:15 pm
	Title XVIII	Hospital	PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	774,296	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	63,063,832	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	23,789	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	63,040,043	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	35,882,340	42.00
43.00	Primary payer payments (see instructions)	4,850	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	35,877,490	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	98,917,533	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.637299	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.362701	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	257,441	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	164,067	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	93,374	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 5/25/2017 3:15 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	29,193,417	0	0	0	1.00
2.00	Temporary investments	281,100,981	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	120,033,260	0	0	0	4.00
5.00	Other receivable	-663,095	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-70,330,984	0	0	0	6.00
7.00	Inventory	7,180,402	0	0	0	7.00
8.00	Prepaid expenses	6,163,999	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	372,677,980	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	13,579,037	0	0	0	12.00
13.00	Land improvements	35,550,113	0	0	0	13.00
14.00	Accumulated depreciation	-20,045,000	0	0	0	14.00
15.00	Buildings	280,957,511	0	0	0	15.00
16.00	Accumulated depreciation	-112,164,309	0	0	0	16.00
17.00	Leasehold improvements	12,344,443	0	0	0	17.00
18.00	Accumulated depreciation	-5,411,838	0	0	0	18.00
19.00	Fixed equipment	2,090,615	0	0	0	19.00
20.00	Accumulated depreciation	-1,256,469	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	171,369,690	0	0	0	23.00
24.00	Accumulated depreciation	-136,274,496	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	240,739,297	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	42,830,201	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	42,830,201	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	656,247,478	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	15,801,995	0	0	0	37.00
38.00	Salaries, wages, and fees payable	20,799,762	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	6,528,503	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	4,278,540				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	47,408,800	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	217,600,195	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	217,600,195	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	265,008,995	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	391,238,483				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)	391,238,483	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	656,247,478	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 5/25/2017 3:15 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		391,442,316		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-203,913				2.00
3.00	Total (sum of line 1 and line 2)		391,238,403		0		3.00
4.00	Additions ROUNDING	80		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)		80		0		10.00
11.00	Subtotal (line 3 plus line 10)		391,238,483		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)		391,238,483		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions ROUNDING		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: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/25/2017 3:15 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	45,088,149		45,088,149	1.00
2.00	SUBPROVIDER - IPF	11,010,358		11,010,358	2.00
3.00	SUBPROVIDER - IRF	3,647,872		3,647,872	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)	59,746,379		59,746,379	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	9,135,875		9,135,875	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	9,135,875		9,135,875	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	68,882,254		68,882,254	17.00
18.00	Ancillary services	188,362,112	420,705,459	609,067,571	18.00
19.00	Outpatient services	26,709	60,556,393	60,583,102	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	835,986	3,081,808	3,917,794	26.00
27.00	OTHER	40,309,044	127,263,306	167,572,350	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	298,416,105	611,606,966	910,023,071	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		414,214,856		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)		414,214,856		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0048 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-3 | Date/Time Prepared: 5/25/2017 3:15 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	910,023,071	1.00
2.00	Less contractual allowances and discounts on patients' accounts	519,642,406	2.00
3.00	Net patient revenues (line 1 minus line 2)	390,380,665	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	414,214,856	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-23,834,191	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	8,054,987	6.00
7.00	Income from investments	19,141,923	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	105,950	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	278,765	13.00
14.00	Revenue from meals sold to employees and guests	3,540,910	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	17,940	17.00
18.00	Revenue from sale of medical records and abstracts	44,029	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	39,252	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	16,928	21.00
22.00	Rental of hospital space	5,886,174	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	-13,496,580	24.00
25.00	Total other income (sum of lines 6-24)	23,630,278	25.00
26.00	Total (line 5 plus line 25)	-203,913	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)	-203,913	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O | Date/Time Prepared: 5/25/2017 3:15 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		9,434	9,434	0	9,434	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	81,823	81,823	0	81,823	3.00
4.00	ADMINISTRATIVE & GENERAL*	183,910	42,225	226,135	0	226,135	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	25	25	0	25	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	3,595	3,595	0	3,595	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	111,524	111,524	0	111,524	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	114,847	114,847	0	114,847	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	771,997	0	771,997	0	771,997	28.00
29.00	LPN/LVN**	6,996	0	6,996	0	6,996	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	89,869	0	89,869	0	89,869	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	88,093	88,093	0	88,093	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	65	65	0	65	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	264,799	264,799	0	264,799	42.00
43.00	OUTPATIENT SERVICES**	0	361,168	361,168	0	361,168	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	317	317	0	317	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	1,052,772	1,077,915	2,130,687	0	2,130,687	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O | Date/Time Prepared: 5/25/2017 3:15 pm

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	9,434		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	-124	81,699		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	226,135		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	25		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	3,595		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	0		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	111,524		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	114,847		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	0		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	771,997		28.00
29.00	LPN/LVN**	0	6,996		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0		33.00
34.00	SPIRITUAL COUNSELING**	0	0		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	89,869		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	88,093		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	65		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	264,799		42.00
43.00	OUTPATIENT SERVICES**	0	361,168		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	-317	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	-441	2,130,246		100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE CONTINUOUS HOME CARE

Provider CCN: 15-0048 Hospice CCN: 15-1524 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O-1 | Date/Time Prepared: 5/25/2017 3:15 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	2,596	0	2,596	0	2,596	28.00
29.00	LPN/LVN	24	0	24	0	24	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	302	0	302	0	302	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	296	296	0	296	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	890	890	0	890	42.00
43.00	OUTPATIENT SERVICES	0	1,214	1,214	0	1,214	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	2,922	2,400	5,322	0	5,322	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 50.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	2,596		28.00
29.00	LPN/LVN	0	24		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	302		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	296		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	890		42.00
43.00	OUTPATIENT SERVICES	0	1,214		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	5,322		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 50.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 15-0048 Hospice CCN: 15-1524 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O-2 | Date/Time Prepared: 5/25/2017 3:15 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	729,378	0	729,378	0	729,378	28.00
29.00	LPN/LVN	6,609	0	6,609	0	6,609	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	84,908	0	84,908	0	84,908	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	83,230	83,230	0	83,230	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	62	62	0	62	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	250,181	250,181	0	250,181	42.00
43.00	OUTPATIENT SERVICES	0	341,230	341,230	0	341,230	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	820,895	674,703	1,495,598	0	1,495,598	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	729,378		28.00
29.00	LPN/LVN	0	6,609		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	84,908		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	83,230		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	62		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	250,181		42.00
43.00	OUTPATIENT SERVICES	0	341,230		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	1,495,598		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPITE CARE

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O-3 | Date/Time Prepared: 5/25/2017 3:15 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	3,634	0	3,634	0	3,634	28.00
29.00	LPN/LVN	33	0	33	0	33	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	423	0	423	0	423	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN						38.00
39.00	PATIENT TRANSPORTATION	0	415	415	0	415	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	1,246	1,246	0	1,246	42.00
43.00	OUTPATIENT SERVICES	0	1,700	1,700	0	1,700	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	4,090	3,361	7,451	0	7,451	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	3,634		28.00
29.00	LPN/LVN	0	33		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	423		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN				38.00
39.00	PATIENT TRANSPORTATION	0	415		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	1,246		42.00
43.00	OUTPATIENT SERVICES	0	1,700		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	7,451		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O-4 | Date/Time Prepared: 5/25/2017 3:15 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	36,389	0	36,389	0	36,389	28.00
29.00	LPN/LVN	330	0	330	0	330	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	4,236	0	4,236	0	4,236	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN						38.00
39.00	PATIENT TRANSPORTATION	0	4,152	4,152	0	4,152	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	3	3	0	3	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	12,482	12,482	0	12,482	42.00
43.00	OUTPATIENT SERVICES	0	17,024	17,024	0	17,024	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	40,955	33,661	74,616	0	74,616	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	36,389		28.00
29.00	LPN/LVN	0	330		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	4,236		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN				38.00
39.00	PATIENT TRANSPORTATION	0	4,152		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	3		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	12,482		42.00
43.00	OUTPATIENT SERVICES	0	17,024		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	74,616		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 15-0048 Hospice CCN: 15-1524 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O-5 | Date/Time Prepared: 5/25/2017 3:15 pm

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	539	539	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,434	0	9,434	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	81,699	135,063	216,762	3.00
4.00	ADMINISTRATIVE & GENERAL	226,135	328,941	555,076	4.00
5.00	PLANT OPERATION & MAINTENANCE	25	0	25	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	19,589	19,589	7.00
8.00	DIETARY	3,595	0	3,595	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	252	252	10.00
11.00	MEDICAL RECORDS	0	36,074	36,074	11.00
12.00	STAFF TRANSPORTATION	0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	111,524	129,174	240,698	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	114,847		114,847	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		28,340	28,340	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	5,322		5,322	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,495,598		1,495,598	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	7,451		7,451	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	74,616		74,616	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	2,130,246	677,972	2,808,218	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0048 Hospice CCN: 15-1524 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O-6 Part I Date/Time Prepared: 5/25/2017 3:15 pm

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	539	539				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,434		9,434			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	216,762	0	0	216,762		3.00
4.00	ADMINISTRATIVE & GENERAL	555,076	539	0	37,866	593,481	4.00
5.00	PLANT OPERATION & MAINTENANCE	25	0	0	0	25	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	19,589	0	0	0	19,589	7.00
8.00	DIETARY	3,595	0	0	0	3,595	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	252	0	0	0	252	10.00
11.00	MEDICAL RECORDS	36,074	0	0	0	36,074	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	240,698	0	0	0	240,698	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	114,847	0	0	0	114,847	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		28,340	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	5,322			602	5,924	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,495,598			169,020	1,664,618	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	7,451	0	848	842	9,141	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	74,616	0	8,586	8,432	91,634	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	2,808,218	539	9,434	216,762	2,808,218	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0048 Hospice CCN: 15-1524 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O-6 Part I Date/Time Prepared: 5/25/2017 3:15 pm

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	593,481					4.00
5.00	PLANT OPERATION & MAINTENANCE	7	32				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	5,249	0		24,838		7.00
8.00	DIETARY	963	0		0	4,558	8.00
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	68	0		0		10.00
11.00	MEDICAL RECORDS	9,667	0		0		11.00
12.00	STAFF TRANSPORTATION	0	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	64,500	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	30,775	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	7,594	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	1,587					50.00
51.00	HOSPICE ROUTINE HOME CARE	446,066					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	2,450	3	0	2,233	414	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	24,555	29	0	22,605	4,144	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	593,481	32	0	24,838	4,558	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0048 Hospice CCN: 15-1524

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

Worksheet O-6 Part I Date/Time Prepared: 5/25/2017 3:15 pm

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	320				10.00
11.00	MEDICAL RECORDS	0		45,741			11.00
12.00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	1	154	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	302	43,216	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	2	215	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	15	2,156	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	320	45,741	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O-6 Part I | Date/Time Prepared: 5/25/2017 3:15 pm

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	305,198					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	145,622				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				35,934		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	1,026	490	0		9,182	50.00
51.00	HOSPICE ROUTINE HOME CARE	288,349	137,582	0		2,580,133	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,437	686	0	3,263	19,844	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	14,386	6,864	0	32,671	199,059	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	305,198	145,622	0	35,934	2,808,218	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0048
Hospice CCN: 15-1524

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

Worksheet O-6
Part II
Date/Time Prepared:
5/25/2017 3:15 pm

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	445					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		445				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,052,772			3.00
4.00	ADMINISTRATIVE & GENERAL	445	0	183,910	-593,481	2,214,737	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	25	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	19,589	7.00
8.00	DIETARY	0	0	0	0	3,595	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	252	10.00
11.00	MEDICAL RECORDS	0	0	0	0	36,074	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	240,698	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	114,847	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	28,340	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			2,922	0	5,924	50.00
51.00	HOSPICE ROUTINE HOME CARE			820,895	0	1,664,618	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	40	4,090	0	9,141	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	405	40,955	0	91,634	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	539	9,434	216,762		593,481	100.00
101.00	UNIT COST MULTIPLIER	1.211236	21.200000	0.205896		0.267969	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0048
Hospice CCN: 15-1524

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

Worksheet O-6
Part II
Date/Time Prepared:
5/25/2017 3:15 pm

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	445					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		445			7.00
8.00	DIETARY	0		0	848		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	40	0	40	77	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	405	0	405	771	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	32	0	24,838	4,558	0	100.00
101.00	UNIT COST MULTIPLIER	0.071910	0.000000	55.815730	5.375000	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0048
Hospice CCN: 15-1524

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

Worksheet O-6
Part II
Date/Time Prepared:
5/25/2017 3:15 pm

Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	16,357					10.00
11.00	MEDICAL RECORDS		16,357				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	16,357	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	55	55	0	0	55	50.00
51.00	HOSPICE ROUTINE HOME CARE	15,454	15,454	0	0	15,454	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	77	77	0	0	77	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	771	771	0	0	771	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	320	45,741	0	0	305,198	100.00
101.00	UNIT COST MULTIPLIER	0.019563	2.796417	0.000000	0.000000	18.658556	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 15-0048
Hospice CCN: 15-1524

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

Worksheet O-6
Part II
Date/Time Prepared:
5/25/2017 3:15 pm

Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	16,357				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			848		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	55	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	15,454	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	77	0	77		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	771	0	771		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	145,622	0	35,934		100.00
101.00	UNIT COST MULTIPLIER	8.902733	0.000000	42.375000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 15-0048 Hospice CCN: 15-1524

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

Worksheet O-7

Date/Time Prepared: 5/25/2017 3:15 pm

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.705437	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.315960	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0.510463	0	0	0	5.00
6.00	LABORATORY	60.00	0.185965	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.157365	0	0	0	7.00
8.00	PATIENT CARE CENTER - OCC	93.00	0.482966	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	ANCILLARY - OTHER	76.00	0.000000	0	0	0	10.00
10.97	CARDIAC REHABILITATION	76.97	0.309649	0	0	0	10.97
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	PATIENT CARE CENTER - OCC	0	0	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	ANCILLARY - OTHER	0	0	0	0	0	10.00
10.97	CARDIAC REHABILITATION	0	0	0	0	0	10.97
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0048 | Hospice CCN: 15-1524 | Period: From 01/01/2016 To 12/31/2016 | Worksheet O-8 | Date/Time Prepared: 5/25/2017 3:15 pm

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			9,182	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			55	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			166.95	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	1	0		4.00
5.00	Program cost (line 3 times line 4)	167	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			2,580,133	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			15,454	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			166.96	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	13,803	672		9.00
10.00	Program cost (line 8 times line 9)	2,304,549	112,197		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			19,844	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			77	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			257.71	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	74	0		14.00
15.00	Program cost (line 13 times line 14)	19,071	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			199,059	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			771	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			258.18	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	640	11		19.00
20.00	Program cost (line 18 times line 19)	165,235	2,840		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			2,808,218	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			16,357	22.00
23.00	Average cost per diem (line 21 divided by line 22)			171.68	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0048	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 5/25/2017 3:15 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	3,858,837	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	120,584	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)	96.42	3.00
4.00	Number of interns & residents (see instructions)	4.39	4.00
5.00	Indirect medical education percentage (see instructions)	1.29	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)	49,779	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	4,029,200	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