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: 15-0102	Period: From 03/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/31/2017 9:21 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/31/2017 Time: 9:21 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH STARKE MEMORIAL HOSPITAL (15-0102) for the cost reporting period beginning 03/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	4,020	48,379	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	4,020	48,379	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2017 8:50 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 102 EAST CULVER RD	PO Box:			1.00
2.00	City: KNOX	State: IN	Zip Code: 46534	County: STARKE	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	IU HEALTH STARKE MEMORIAL HOSPITAL	150102	99915	1	07/11/1966	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	IU HEALTH STARKE MEMORIAL SWING BED	15U102	99915		09/06/1989	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	191	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2017 8:50 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	1		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	03/01/2016	12/31/2016	38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2017 8:50 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2017 8:50 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/31/2017 8:50 am

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	3,738	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	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/31/2017 8:50 am

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

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: CHS/COMMUNITY HEALTH SYTEMS, INC	Contractor's Name: WPS	Contractor's Number: 08001	141.00
142.00	Street: 4000 MERIDIAN BOULEVARD	PO Box: N/A		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0102	Period: From 03/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/31/2017 8:50 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2016	09/28/2016	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: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 5/31/2017 8:50 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/25/2017	Y	04/25/2017	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: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 5/31/2017 8:50 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BEN		DEBOER		41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-3305		BENJAMIN_DEBOER@CHS.NET		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0102	Period: From 03/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/31/2017 8:50 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER, REVENUE MANAGEMENT		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: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/31/2017 8:50 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	47	14,382	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)		47	14,382	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	3	918	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						13.00
14.00	Total (see instructions)		50	15,300	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		50				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: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2017 8:50 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	52	191	1,099			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	52	191	1,099			7.00
8.00	INTENSIVE CARE UNIT	0	0	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						13.00
14.00	Total (see instructions)	52	191	1,099	0.00	95.71	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	95.71	27.00
28.00	Observation Bed Days		0	699			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/31/2017 8:50 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		15	201	68	365	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
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	15	201	68	365	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2017 8:50 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	5,293,427	0	5,293,427	199,084.00	26.59	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		375	0	375	3.00	125.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	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)		0	0	0	0.00	0.00	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		233,418	0	233,418	3,340.00	69.89	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		375	0	375	3.00	125.00	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)		1,242,011	0	1,242,011			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		0	0	0			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		30	0	30			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		0	0	0			25.50
25.51	Related orgainzation wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	368,538	-44,629	323,909	15,001.00	21.59	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 5/31/2017 8:50 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		2,423	0	2,423	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	301,769	0	301,769	13,904.00	21.70	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	169,426	0	169,426	12,125.00	13.97	32.00
33.00	Housekeeping under contract (see instructions)		73,395	0	73,395	4,042.00	18.16	33.00
34.00	Dietary	10.00	158,168	-83,405	74,763	3,554.00	21.04	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	83,405	83,405	4,002.00	20.84	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	31,573	44,629	76,202	1,801.00	42.31	38.00
39.00	Central Services and Supply	14.00	78,211	0	78,211	3,500.00	22.35	39.00
40.00	Pharmacy	15.00	167,327	0	167,327	4,417.00	37.88	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	2,058.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-3 Part III Date/Time Prepared: 5/31/2017 8:50 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		5,369,245	0	5,369,245	203,126.00	26.43	1.00
2.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		5,369,245	0	5,369,245	203,126.00	26.43	3.00
4.00	Subtotal other wages & related costs (see inst.)		233,793	0	233,793	3,343.00	69.94	4.00
5.00	Subtotal wage-related costs (see inst.)		1,242,041	0	1,242,041	0.00	23.13	5.00
6.00	Total (sum of lines 3 thru 5)		6,845,079	0	6,845,079	206,469.00	33.15	6.00
7.00	Total overhead cost (see instructions)		1,350,830	0	1,350,830	64,404.00	20.97	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-3 Part IV Date/Time Prepared: 5/31/2017 8:50 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	73,077	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	608,166	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	26,283	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	3,347	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	689	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	17,754	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	78,101	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	318,968	17.00
18.00	Medicare Taxes - Employers Portion Only	74,597	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	40,100	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,241,082	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	958	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-3 Part V Date/Time Prepared: 5/31/2017 8:50 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	233,418	1,241,082	1.00
2.00	Hospital	233,418	1,241,082	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 5/31/2017 8:50 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.154584	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,941,311	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	276,867	5.00
6.00	Medicaid charges	20,155,381	6.00
7.00	Medicaid cost (line 1 times line 6)	3,115,699	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)	897,521	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)	897,521	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	1,599,158	310,558	1,909,716	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	247,204	48,007	295,211	21.00
22.00	Partial payment by patients approved for charity care	5,097	110	5,207	22.00
23.00	Cost of charity care (line 21 minus line 22)	242,107	47,897	290,004	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,067,322	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	55,658	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	4,011,664	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	620,139	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	910,143	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,807,664	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/31/2017 8:50 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		489,872	489,872	206,580	696,452	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		916,884	916,884	64,197	981,081	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	592	592	808,376	808,968	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	368,538	2,904,872	3,273,410	-1,249,906	2,023,504	5.00
7.00	00700	OPERATION OF PLANT	301,769	676,646	978,415	-1,434	976,981	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,162	15,162	0	15,162	8.00
9.00	00900	HOUSEKEEPING	169,426	151,250	320,676	0	320,676	9.00
10.00	01000	DIETARY	158,168	111,401	269,569	-144,200	125,369	10.00
11.00	01100	CAFETERIA	0	0	0	144,200	144,200	11.00
13.00	01300	NURSING ADMINISTRATION	31,573	10,039	41,612	44,629	86,241	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	78,211	-36,187	42,024	-96,519	-54,495	14.00
15.00	01500	PHARMACY	167,327	581,364	748,691	-558,963	189,728	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	318,427	318,427	0	318,427	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	895,138	122,178	1,017,316	0	1,017,316	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	507,836	715,286	1,223,122	-29,968	1,193,154	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	258,473	258,473	0	258,473	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	749,610	609,974	1,359,584	-339	1,359,245	54.00
54.01	05401	ULTRASOUND	82,542	12,058	94,600	0	94,600	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	5,200	33,287	38,487	0	38,487	57.00
58.00	05800	MRI	72,985	109,530	182,515	0	182,515	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	406,754	690,081	1,096,835	-7,860	1,088,975	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	234,051	32,278	266,329	-5,164	261,165	65.00
66.00	06600	PHYSICAL THERAPY	192,704	199,408	392,112	0	392,112	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	67,914	15,250	83,164	0	83,164	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	120,845	120,845	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,642	5,642	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	558,963	558,963	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.01
76.02	03040	AUDIOLOGY	0	0	0	0	0	76.02
76.03	03060	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	803,681	2,126,850	2,930,531	0	2,930,531	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,293,427	11,064,975	16,358,402	-140,921	16,217,481	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-119,539	-119,539	140,044	20,505	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	0	0	0	0	0	193.01
193.02	19302	VACANT	0	0	0	0	0	193.02
193.03	19303	NONPAID WORKERS	0	0	0	0	0	193.03
194.00	07950	SPECIALTY CLINIC / MOB	0	0	0	0	0	194.00
194.01	07952	OTHER NONREIMBURSABLE CC	0	0	0	877	877	194.01
200.00		TOTAL (SUM OF LINES 118-199)	5,293,427	10,945,436	16,238,863	0	16,238,863	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/31/2017 8:50 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-19,500	676,952		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	981,081		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	808,968		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-791,536	1,231,968		5.00
7.00	00700	OPERATION OF PLANT	0	976,981		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,162		8.00
9.00	00900	HOUSEKEEPING	0	320,676		9.00
10.00	01000	DIETARY	0	125,369		10.00
11.00	01100	CAFETERIA	-65,538	78,662		11.00
13.00	01300	NURSING ADMINISTRATION	-280	85,961		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-54,495		14.00
15.00	01500	PHARMACY	-18,988	170,740		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	318,427		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,017,316		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-220,792	972,362		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	-253,793	4,680		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,359,245		54.00
54.01	05401	ULTRASOUND	0	94,600		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	-262	38,225		57.00
58.00	05800	MRI	0	182,515		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	1,088,975		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	261,165		65.00
66.00	06600	PHYSICAL THERAPY	-2,398	389,714		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	83,164		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	120,845		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,642		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	558,963		73.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0		76.01
76.02	03040	AUDIOLOGY	0	0		76.02
76.03	03060	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-1,831,795	1,098,736		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,204,882	13,012,599		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	20,505		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	WELLNESS CENTER	0	0		193.01
193.02	19302	VACANT	0	0		193.02
193.03	19303	NONPAID WORKERS	0	0		193.03
194.00	07950	SPECIALTY CLINIC / MOB	-121	-121		194.00
194.01	07952	OTHER NONREIMBURSABLE CC	0	877		194.01
200.00		TOTAL (SUM OF LINES 118-199)	-3,205,003	13,033,860		200.00

RECLASSIFICATIONS | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/31/2017 8:50 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RENTAL & LEASE EXPENSES				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	57,217	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	140,044	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	0		0	197,261	
	B - MEALS				
1.00	CAFETERIA	11.00	83,405	60,795	1.00
	0		83,405	60,795	
	C - DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	558,963	1.00
	0		0	558,963	
	D - SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	91,379	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,642	2.00
	0		0	97,021	
	E - CNO SALARIES				
1.00	NURSING ADMINISTRATION	13.00	44,629	0	1.00
	0		44,629	0	
	F - RECLASS OXYGEN COSTS				
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	29,466	1.00
	0		0	29,466	
	H - RECLASS OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	25,643	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	180,937	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,980	3.00
4.00		0.00	0	0	4.00
	0		0	213,560	
	I - RECLASS MARKETING DEPT				
1.00	OTHER NONREIMBURSABLE CC	194.01	0	877	1.00
	0		0	877	
	K - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	808,376	1.00
	0		0	808,376	
500.00	Grand Total: Increases		128,034	1,966,319	500.00

RECLASSIFICATIONS | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/31/2017 8:50 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RENTAL & LEASE EXPENSES						
1.00		0.00	0	0	12		1.00
2.00		0.00	0	0	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	182,464	0		3.00
4.00	OPERATION OF PLANT	7.00	0	1,434	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	339	0		5.00
6.00	LABORATORY	60.00	0	7,860	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	5,164	0		7.00
	0		0	197,261			
	B - MEALS						
1.00	DIETARY	10.00	83,405	60,795	0		1.00
	0		83,405	60,795			
	C - DRUGS						
1.00	PHARMACY	15.00	0	558,963	0		1.00
	0		0	558,963			
	D - SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	67,053	0		1.00
2.00	OPERATING ROOM	50.00	0	29,968	0		2.00
	0		0	97,021			
	E - CNO SALARIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	44,629	0	0		1.00
	0		44,629	0			
	F - RECLASS OXYGEN COSTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	29,466	0		1.00
	0		0	29,466			
	H - RECLASS OTHER CAPITAL COSTS						
1.00		0.00	0	0	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	213,560	0		4.00
	0		0	213,560			
	I - RECLASS MARKETING DEPT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	877	0		1.00
	0		0	877			
	K - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	808,376	0		1.00
	0		0	808,376			
500.00	Grand Total: Decreases		128,034	1,966,319			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 5/31/2017 8:50 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	142,789	0	0	0	142,789	1.00
2.00	Land Improvements	37,448	0	0	0	37,448	2.00
3.00	Buildings and Fixtures	1,509,571	0	0	0	1,509,571	3.00
4.00	Building Improvements	5,144,332	71,206	0	71,206	5,144,332	4.00
5.00	Fixed Equipment	0	3,944	0	3,944	0	5.00
6.00	Movable Equipment	9,769,509	3,421,012	0	3,421,012	9,769,509	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,603,649	3,496,162	0	3,496,162	16,603,649	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	16,603,649	3,496,162	0	3,496,162	16,603,649	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	71,206	0	4.00
5.00	Fixed Equipment	3,944	0	5.00
6.00	Movable Equipment	3,421,012	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	3,496,162	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	3,496,162	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet A-7 Part II Date/Time Prepared: 5/31/2017 8:50 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	489,872	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	916,884	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,406,756	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	489,872	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	916,884	2.00
3.00	Total (sum of lines 1-2)	0	1,406,756	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 5/31/2017 8:50 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	75,150	0	75,150	0.021495	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,421,012	0	3,421,012	0.978505	0	2.00
3.00	Total (sum of lines 1-2)	3,496,162	0	3,496,162	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	489,872	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	916,884	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,406,756	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-19,500	25,643	180,937	0	676,952	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	64,197	0	0	981,081	2.00
3.00	Total (sum of lines 1-2)	-19,500	89,840	180,937	0	1,658,033	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/31/2017 8:50 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-19,500	CAP REL COSTS-BLDG & FIXT	1.00	11	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	-2,327,571			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	-541,737			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-65,538	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-18,988	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	TRAINING REVENUE	B	-280	NURSING ADMINISTRATION	13.00	0	33.00
33.01	MISC NON-PATIENT REVENUE	B	-8,523	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/31/2017 8:50 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	ADVERTISING	A	-34,803	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	GRANT INCOME	B	-25,577	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	OTHER MISC REVENUE	B	-136,465	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	CHARITABLE CONTRIBUTIONS	A	-2,385	PHYSICAL THERAPY	66.00	0	33.05
33.06	PATIENT TELEPHONES	A	-17,228	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PATIENT TELEVISION	A	-6,287	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	SPECIAL EVENTS	A	-121	SPECIALTY CLINIC / MOB	194.00	0	33.08
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,205,003				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: 15-0102	Period: From 03/01/2016 To 12/31/2016	Worksheet A-8-1 Date/Time Prepared: 5/31/2017 8:50 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00			0	0	1.00
2.00	0.00			0	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL	0	358,207	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	0	183,530	4.00
4.02	0.00			0	0	4.02
4.03	0.00			0	0	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			0	541,737	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.

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0102	Period: From 03/01/2016 To 12/31/2016	Worksheet A-8-1 Date/Time Prepared: 5/31/2017 8:50 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	9		1.00
2.00	0	9		2.00
3.00	-358,207	0		3.00
4.00	-183,530	0		4.00
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
5.00	-541,737			5.00

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

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

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

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

6.00	HEALTH SYSTEM		6.00
7.00	HEALTH SYSTEM		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: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 5/31/2017 8:50 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	20,916	20,916	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	220,792	220,792	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	253,793	253,793	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	57.00	CT SCAN	262	262	0	0	0	8.00
9.00	60.00	LABORATORY	0	0	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	10.00
11.00	66.00	PHYSICAL THERAPY	13	13	0	0	0	11.00
12.00	90.00	CLINIC	0	0	0	0	0	12.00
13.00	91.00	EMERGENCY	1,831,795	1,831,795	0	0	0	13.00
200.00			2,327,571	2,327,571	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	57.00	CT SCAN	0	0	0	0	0	8.00
9.00	60.00	LABORATORY	0	0	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	10.00
11.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	11.00
12.00	90.00	CLINIC	0	0	0	0	0	12.00
13.00	91.00	EMERGENCY	0	0	0	0	0	13.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	20,916		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	50.00	OPERATING ROOM	0	0	0	220,792		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	253,793		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0		7.00
8.00	57.00	CT SCAN	0	0	0	262		8.00
9.00	60.00	LABORATORY	0	0	0	0		9.00
10.00	65.00	RESPIRATORY THERAPY	0	0	0	0		10.00
11.00	66.00	PHYSICAL THERAPY	0	0	0	13		11.00
12.00	90.00	CLINIC	0	0	0	0		12.00
13.00	91.00	EMERGENCY	0	0	0	1,831,795		13.00
200.00			0	0	0	2,327,571		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/31/2017 8:50 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	676,952	676,952				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	981,081		981,081			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	808,968	1,236	1,792	811,996		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,231,968	34,599	50,144	49,687	1,366,398	5.00
7.00	00700	OPERATION OF PLANT	976,981	146,662	212,549	46,290	1,382,482	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,162	0	0	0	15,162	8.00
9.00	00900	HOUSEKEEPING	320,676	14,727	21,343	25,989	382,735	9.00
10.00	01000	DIETARY	125,369	16,600	24,058	11,468	177,495	10.00
11.00	01100	CAFETERIA	78,662	4,383	6,352	12,794	102,191	11.00
13.00	01300	NURSING ADMINISTRATION	85,961	4,916	7,125	11,689	109,691	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-54,495	10,292	14,915	11,997	-17,291	14.00
15.00	01500	PHARMACY	170,740	8,700	12,608	25,667	217,715	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	318,427	6,716	9,733	0	334,876	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,017,316	57,130	82,797	137,312	1,294,555	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	972,362	62,624	90,759	77,901	1,203,646	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	4,680	0	0	0	4,680	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,359,245	63,564	92,122	114,988	1,629,919	54.00
54.01	05401	ULTRASOUND	94,600	0	0	12,662	107,262	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	38,225	3,554	5,151	798	47,728	57.00
58.00	05800	MRI	182,515	9,374	13,585	11,196	216,670	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,088,975	14,527	21,053	62,395	1,186,950	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	261,165	8,352	12,104	35,903	317,524	65.00
66.00	06600	PHYSICAL THERAPY	389,714	17,940	26,000	29,560	463,214	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	718	1,041	0	1,759	68.00
69.00	06900	ELECTROCARDIOLOGY	83,164	3,954	5,730	10,418	103,266	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	120,845	0	0	0	120,845	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,642	0	0	0	5,642	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	558,963	0	0	0	558,963	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.01
76.02	03040	AUDIOLOGY	0	0	0	0	0	76.02
76.03	03060	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,098,736	27,758	40,229	123,282	1,290,005	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,012,599	518,326	751,190	811,996	12,624,082	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	3,687	5,344	0	9,031	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,505	0	0	0	20,505	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	0	0	0	0	0	193.01
193.02	19302	VACANT	0	16,163	23,425	0	39,588	193.02
193.03	19303	NONPAID WORKERS	0	0	0	0	0	193.03
194.00	07950	SPECIALTY CLINIC / MOB	-121	138,776	201,122	0	339,777	194.00
194.01	07952	OTHER NONREIMBURSABLE CC	877	0	0	0	877	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	13,033,860	676,952	981,081	811,996	13,033,860	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/31/2017 8:50 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,366,398					5.00
7.00	00700	OPERATION OF PLANT	161,666	1,544,148				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,773	0	16,935			8.00
9.00	00900	HOUSEKEEPING	44,757	45,991	0	473,483		9.00
10.00	01000	DIETARY	20,756	51,841	0	16,384	266,476	10.00
11.00	01100	CAFETERIA	11,950	13,689	0	4,326	182,407	11.00
13.00	01300	NURSING ADMINISTRATION	12,827	15,353	0	4,852	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	32,140	0	10,158	0	14.00
15.00	01500	PHARMACY	25,459	27,169	0	8,587	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	39,160	20,972	0	6,628	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	151,384	178,414	5,645	56,387	83,405	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	140,753	195,571	5,645	61,810	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	547	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	190,596	198,507	0	62,738	0	54.00
54.01	05401	ULTRASOUND	12,543	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	5,581	11,099	0	3,508	0	57.00
58.00	05800	MRI	25,337	29,273	0	9,252	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	138,801	45,366	0	14,338	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	37,131	26,082	0	8,243	0	65.00
66.00	06600	PHYSICAL THERAPY	54,168	56,026	0	17,707	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	206	2,243	0	709	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12,076	12,347	0	3,902	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	14,131	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	660	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,365	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.01
76.02	03040	AUDIOLOGY	0	0	0	0	0	76.02
76.03	03060	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	150,852	86,686	5,645	27,397	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,318,479	1,048,769	16,935	316,926	265,812	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	1,056	11,515	0	3,639	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,398	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	0	0	0	0	213	193.01
193.02	19302	VACANT	4,629	50,477	0	15,953	0	193.02
193.03	19303	NONPAID WORKERS	0	0	0	0	0	193.03
194.00	07950	SPECIALTY CLINIC / MOB	39,733	433,387	0	136,965	451	194.00
194.01	07952	OTHER NONREIMBURSABLE CC	103	0	0	0	0	194.01
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)	1,366,398	1,544,148	16,935	473,483	266,476	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/31/2017 8:50 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	314,563					11.00
13.00	01300	NURSING ADMINISTRATION	3,835	146,558				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,405	0	32,412			14.00
15.00	01500	PHARMACY	9,344	8,549	0	296,823		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	32	0	401,668	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	69,463	45,731	1,743	0	33,171	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,243	25,945	9,465	0	47,006	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	117	0	12,107	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,154	0	2,957	0	26,095	54.00
54.01	05401	ULTRASOUND	4,407	0	27	0	9,102	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	309	0	116	0	46,420	57.00
58.00	05800	MRI	3,746	0	67	0	19,376	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	30,103	0	9,217	0	62,214	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	577	62.00
65.00	06500	RESPIRATORY THERAPY	17,542	11,958	306	0	4,885	65.00
66.00	06600	PHYSICAL THERAPY	7,140	9,845	103	0	5,901	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,231	0	0	0	899	67.00
68.00	06800	SPEECH PATHOLOGY	2,953	0	0	0	1,021	68.00
69.00	06900	ELECTROCARDIOLOGY	4,936	3,470	83	0	14,352	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	3,870	0	2,733	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	269	0	876	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	296,823	36,022	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.01
76.02	03040	AUDIOLOGY	0	0	0	0	0	76.02
76.03	03060	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	58,752	41,060	4,040	0	78,911	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	314,563	146,558	32,412	296,823	401,668	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	0	0	0	0	0	193.01
193.02	19302	VACANT	0	0	0	0	0	193.02
193.03	19303	NONPAID WORKERS	0	0	0	0	0	193.03
194.00	07950	SPECIALTY CLINIC / MOB	0	0	0	0	0	194.00
194.01	07952	OTHER NONREIMBURSABLE CC	0	0	0	0	0	194.01
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)	314,563	146,558	32,412	296,823	401,668	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/31/2017 8:50 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,919,898	0	1,919,898		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,727,084	0	1,727,084		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	17,451	0	17,451		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,163,966	0	2,163,966		54.00
54.01	05401	ULTRASOUND	0	133,341	0	133,341		54.01
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	114,761	0	114,761		57.00
58.00	05800	MRI	0	303,721	0	303,721		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	1,486,989	0	1,486,989		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	577	0	577		62.00
65.00	06500	RESPIRATORY THERAPY	0	423,671	0	423,671		65.00
66.00	06600	PHYSICAL THERAPY	0	614,104	0	614,104		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,130	0	5,130		67.00
68.00	06800	SPEECH PATHOLOGY	0	8,891	0	8,891		68.00
69.00	06900	ELECTROCARDIOLOGY	0	154,432	0	154,432		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	141,579	0	141,579		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,447	0	7,447		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	957,173	0	957,173		73.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	0	0		76.01
76.02	03040	AUDIOLOGY	0	0	0	0		76.02
76.03	03060	WOUND CARE	0	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	1,743,348	0	1,743,348		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	11,923,563	0	11,923,563		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	25,241	0	25,241		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	22,903	0	22,903		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	WELLNESS CENTER	0	213	0	213		193.01
193.02	19302	VACANT	0	110,647	0	110,647		193.02
193.03	19303	NONPAID WORKERS	0	0	0	0		193.03
194.00	07950	SPECIALTY CLINIC / MOB	0	950,313	0	950,313		194.00
194.01	07952	OTHER NONREIMBURSABLE CC	0	980	0	980		194.01
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	13,033,860	0	13,033,860		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/31/2017 8:50 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,236	1,792	3,028	3,028	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	34,599	50,144	84,743	185	5.00
7.00	00700	OPERATION OF PLANT	0	146,662	212,549	359,211	173	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	14,727	21,343	36,070	97	9.00
10.00	01000	DIETARY	0	16,600	24,058	40,658	43	10.00
11.00	01100	CAFETERIA	0	4,383	6,352	10,735	48	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,916	7,125	12,041	44	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,292	14,915	25,207	45	14.00
15.00	01500	PHARMACY	0	8,700	12,608	21,308	96	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,716	9,733	16,449	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	57,130	82,797	139,927	510	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	62,624	90,759	153,383	290	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	63,564	92,122	155,686	429	54.00
54.01	05401	ULTRASOUND	0	0	0	0	47	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	3,554	5,151	8,705	3	57.00
58.00	05800	MRI	0	9,374	13,585	22,959	42	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	14,527	21,053	35,580	233	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	8,352	12,104	20,456	134	65.00
66.00	06600	PHYSICAL THERAPY	0	17,940	26,000	43,940	110	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	718	1,041	1,759	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,954	5,730	9,684	39	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.01
76.02	03040	AUDIOLOGY	0	0	0	0	0	76.02
76.03	03060	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	27,758	40,229	67,987	460	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	518,326	751,190	1,269,516	3,028	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	3,687	5,344	9,031	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	0	0	0	0	0	193.01
193.02	19302	VACANT	0	16,163	23,425	39,588	0	193.02
193.03	19303	NONPAID WORKERS	0	0	0	0	0	193.03
194.00	07950	SPECIALTY CLINIC / MOB	0	138,776	201,122	339,898	0	194.00
194.01	07952	OTHER NONREIMBURSABLE CC	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	676,952	981,081	1,658,033	3,028	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/31/2017 8:50 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	84,928					5.00
7.00	00700	OPERATION OF PLANT	10,048	369,432				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	110	0	110			8.00
9.00	00900	HOUSEKEEPING	2,782	11,003	0	49,952		9.00
10.00	01000	DIETARY	1,290	12,403	0	1,729	56,123	10.00
11.00	01100	CAFETERIA	743	3,275	0	456	38,417	11.00
13.00	01300	NURSING ADMINISTRATION	797	3,673	0	512	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,689	0	1,072	0	14.00
15.00	01500	PHARMACY	1,582	6,500	0	906	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,434	5,018	0	699	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,409	42,685	36	5,949	17,566	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,748	46,790	37	6,521	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	34	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,847	47,492	0	6,619	0	54.00
54.01	05401	ULTRASOUND	780	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	347	2,655	0	370	0	57.00
58.00	05800	MRI	1,575	7,004	0	976	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	8,627	10,854	0	1,513	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,308	6,240	0	870	0	65.00
66.00	06600	PHYSICAL THERAPY	3,367	13,404	0	1,868	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	13	537	0	75	0	68.00
69.00	06900	ELECTROCARDIOLOGY	751	2,954	0	412	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	878	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	41	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,063	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.01
76.02	03040	AUDIOLOGY	0	0	0	0	0	76.02
76.03	03060	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	9,376	20,739	37	2,890	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	81,950	250,915	110	33,437	55,983	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	66	2,755	0	384	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	149	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	0	0	0	0	45	193.01
193.02	19302	VACANT	288	12,076	0	1,683	0	193.02
193.03	19303	NONPAID WORKERS	0	0	0	0	0	193.03
194.00	07950	SPECIALTY CLINIC / MOB	2,469	103,686	0	14,448	95	194.00
194.01	07952	OTHER NONREIMBURSABLE CC	6	0	0	0	0	194.01
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)	84,928	369,432	110	49,952	56,123	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/31/2017 8:50 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	53,674					11.00
13.00	01300	NURSING ADMINISTRATION	654	17,721				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,263	0	13,156			14.00
15.00	01500	PHARMACY	1,594	1,034	0	33,020		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	13	0	24,613	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,853	5,530	708	0	2,032	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,355	3,137	3,841	0	2,880	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	48	0	742	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,070	0	1,200	0	1,599	54.00
54.01	05401	ULTRASOUND	752	0	11	0	558	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	53	0	47	0	2,844	57.00
58.00	05800	MRI	639	0	27	0	1,187	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	5,137	0	3,741	0	3,811	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	35	62.00
65.00	06500	RESPIRATORY THERAPY	2,993	1,446	124	0	299	65.00
66.00	06600	PHYSICAL THERAPY	1,218	1,190	42	0	362	66.00
67.00	06700	OCCUPATIONAL THERAPY	722	0	0	0	55	67.00
68.00	06800	SPEECH PATHOLOGY	504	0	0	0	63	68.00
69.00	06900	ELECTROCARDIOLOGY	842	420	34	0	879	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	1,571	0	167	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	109	0	54	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	33,020	2,207	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.01
76.02	03040	AUDIOLOGY	0	0	0	0	0	76.02
76.03	03060	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	10,025	4,964	1,640	0	4,839	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	53,674	17,721	13,156	33,020	24,613	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	0	0	0	0	0	193.01
193.02	19302	VACANT	0	0	0	0	0	193.02
193.03	19303	NONPAID WORKERS	0	0	0	0	0	193.03
194.00	07950	SPECIALTY CLINIC / MOB	0	0	0	0	0	194.00
194.01	07952	OTHER NONREIMBURSABLE CC	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	22,120	0	0	201.00
202.00		TOTAL (sum lines 118-201)	53,674	17,721	35,276	33,020	24,613	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/31/2017 8:50 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	236,205	0	236,205		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	231,982	0	231,982		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	824	0	824		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	233,942	0	233,942		54.00
54.01	05401	ULTRASOUND	0	2,148	0	2,148		54.01
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	15,024	0	15,024		57.00
58.00	05800	MRI	0	34,409	0	34,409		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	69,496	0	69,496		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	35	0	35		62.00
65.00	06500	RESPIRATORY THERAPY	0	34,870	0	34,870		65.00
66.00	06600	PHYSICAL THERAPY	0	65,501	0	65,501		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	777	0	777		67.00
68.00	06800	SPEECH PATHOLOGY	0	2,951	0	2,951		68.00
69.00	06900	ELECTROCARDIOLOGY	0	16,015	0	16,015		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	2,616	0	2,616		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	204	0	204		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	39,290	0	39,290		73.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	0	0		76.01
76.02	03040	AUDIOLOGY	0	0	0	0		76.02
76.03	03060	WOUND CARE	0	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	122,957	0	122,957		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,109,246	0	1,109,246		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	12,236	0	12,236		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	149	0	149		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	WELLNESS CENTER	0	45	0	45		193.01
193.02	19302	VACANT	0	53,635	0	53,635		193.02
193.03	19303	NONPAID WORKERS	0	0	0	0		193.03
194.00	07950	SPECIALTY CLINIC / MOB	0	460,596	0	460,596		194.00
194.01	07952	OTHER NONREIMBURSABLE CC	0	6	0	6		194.01
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	22,120	0	22,120		201.00
202.00		TOTAL (sum lines 118-201)	0	1,658,033	0	1,658,033		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/31/2017 8:50 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	91,429					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		91,429				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	167	167	5,293,427			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,673	4,673	323,909	-1,366,398	11,684,753	5.00
7.00	00700	OPERATION OF PLANT	19,808	19,808	301,769	0	1,382,482	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	15,162	8.00
9.00	00900	HOUSEKEEPING	1,989	1,989	169,426	0	382,735	9.00
10.00	01000	DIETARY	2,242	2,242	74,763	0	177,495	10.00
11.00	01100	CAFETERIA	592	592	83,405	0	102,191	11.00
13.00	01300	NURSING ADMINISTRATION	664	664	76,202	0	109,691	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,390	1,390	78,211	17,291	0	14.00
15.00	01500	PHARMACY	1,175	1,175	167,327	0	217,715	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	907	907	0	0	334,876	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,716	7,716	895,138	0	1,294,555	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,458	8,458	507,836	0	1,203,646	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	4,680	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,585	8,585	749,610	0	1,629,919	54.00
54.01	05401	ULTRASOUND	0	0	82,542	0	107,262	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	480	480	5,200	0	47,728	57.00
58.00	05800	MRI	1,266	1,266	72,985	0	216,670	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,962	1,962	406,754	0	1,186,950	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,128	1,128	234,051	0	317,524	65.00
66.00	06600	PHYSICAL THERAPY	2,423	2,423	192,704	0	463,214	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	97	97	0	0	1,759	68.00
69.00	06900	ELECTROCARDIOLOGY	534	534	67,914	0	103,266	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	120,845	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,642	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	558,963	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.01
76.02	03040	AUDIOLOGY	0	0	0	0	0	76.02
76.03	03060	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,749	3,749	803,681	0	1,290,005	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	70,005	70,005	5,293,427	-1,349,107	11,274,975	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	498	498	0	0	9,031	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	20,505	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	0	0	0	0	0	193.01
193.02	19302	VACANT	2,183	2,183	0	0	39,588	193.02
193.03	19303	NONPAID WORKERS	0	0	0	0	0	193.03
194.00	07950	SPECIALTY CLINIC / MOB	18,743	18,743	0	0	339,777	194.00
194.01	07952	OTHER NONREIMBURSABLE CC	0	0	0	0	877	194.01
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)	676,952	981,081	811,996		1,366,398	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.404128	10.730523	0.153397		0.116939	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			3,028		84,928	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000572		0.007268	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/31/2017 8:50 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	66,781					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	93,235				8.00
9.00	00900	HOUSEKEEPING	1,989	0	64,791			9.00
10.00	01000	DIETARY	2,242	0	2,242	32,480		10.00
11.00	01100	CAFETERIA	592	0	592	22,233	7,137	11.00
13.00	01300	NURSING ADMINISTRATION	664	0	664	0	87	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,390	0	1,390	0	168	14.00
15.00	01500	PHARMACY	1,175	0	1,175	0	212	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	907	0	907	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,716	31,079	7,716	10,166	1,576	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,458	31,078	8,458	0	845	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,585	0	8,585	0	1,206	54.00
54.01	05401	ULTRASOUND	0	0	0	0	100	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	480	0	480	0	7	57.00
58.00	05800	MRI	1,266	0	1,266	0	85	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,962	0	1,962	0	683	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,128	0	1,128	0	398	65.00
66.00	06600	PHYSICAL THERAPY	2,423	0	2,423	0	162	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	96	67.00
68.00	06800	SPEECH PATHOLOGY	97	0	97	0	67	68.00
69.00	06900	ELECTROCARDIOLOGY	534	0	534	0	112	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.01
76.02	03040	AUDIOLOGY	0	0	0	0	0	76.02
76.03	03060	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,749	31,078	3,749	0	1,333	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	45,357	93,235	43,368	32,399	7,137	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	498	0	498	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	0	0	0	26	0	193.01
193.02	19302	VACANT	2,183	0	2,183	0	0	193.02
193.03	19303	NONPAID WORKERS	0	0	0	0	0	193.03
194.00	07950	SPECIALTY CLINIC / MOB	18,743	0	18,742	55	0	194.00
194.01	07952	OTHER NONREIMBURSABLE CC	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,544,148	16,935	473,483	266,476	314,563	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.122565	0.181638	7.307851	8.204310	44.074961	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	369,432	110	49,952	56,123	53,674	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.531993	0.001180	0.770971	1.727925	7.520527	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/31/2017 8:50 am

		Cost Center Description	NURSING ADMINISTRATION (TOTAL NURSING SALAR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	2,868,651					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	847,274				14.00
15.00	01500	PHARMACY	167,327	0	560,763			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	848	0	77,133,100		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	895,138	45,576	0	6,370,408	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	507,836	247,366	0	9,027,454	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	3,060	0	2,325,096	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	77,300	0	5,011,563	0	54.00
54.01	05401	ULTRASOUND	0	711	0	1,748,107	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	3,038	0	8,915,014	0	57.00
58.00	05800	MRI	0	1,759	0	3,721,195	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	240,952	0	11,948,137	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	110,779	0	62.00
65.00	06500	RESPIRATORY THERAPY	234,051	8,007	0	938,253	0	65.00
66.00	06600	PHYSICAL THERAPY	192,704	2,683	0	1,133,354	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	172,662	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	196,026	0	68.00
69.00	06900	ELECTROCARDIOLOGY	67,914	2,163	0	2,756,371	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	101,156	0	524,796	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,032	0	168,201	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	560,763	6,917,935	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.01
76.02	03040	AUDIOLOGY	0	0	0	0	0	76.02
76.03	03060	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	803,681	105,615	0	15,147,749	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,868,651	847,266	560,763	77,133,100	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	WELLNESS CENTER	0	0	0	0	0	193.01
193.02	19302	VACANT	0	0	0	0	0	193.02
193.03	19303	NONPAID WORKERS	0	0	0	0	0	193.03
194.00	07950	SPECIALTY CLINIC / MOB	0	0	0	0	0	194.00
194.01	07952	OTHER NONREIMBURSABLE CC	0	0	0	0	0	194.01
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)	146,558	32,412	296,823	401,668	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.051090	0.038254	0.529320	0.005207	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	17,721	35,276	33,020	24,613	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006177	0.015527	0.058884	0.000319	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/31/2017 8:50 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,919,898		1,919,898	0	1,919,898	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,727,084		1,727,084	0	1,727,084	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	17,451		17,451	0	17,451	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,163,966		2,163,966	0	2,163,966	54.00
54.01	05401	ULTRASOUND	133,341		133,341	0	133,341	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	114,761		114,761	0	114,761	57.00
58.00	05800	MRI	303,721		303,721	0	303,721	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,486,989		1,486,989	0	1,486,989	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	577		577	0	577	62.00
65.00	06500	RESPIRATORY THERAPY	423,671	0	423,671	0	423,671	65.00
66.00	06600	PHYSICAL THERAPY	614,104	0	614,104	0	614,104	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,130	0	5,130	0	5,130	67.00
68.00	06800	SPEECH PATHOLOGY	8,891	0	8,891	0	8,891	68.00
69.00	06900	ELECTROCARDIOLOGY	154,432		154,432	0	154,432	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	141,579		141,579	0	141,579	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,447		7,447	0	7,447	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	957,173		957,173	0	957,173	73.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0		0	0	0	76.01
76.02	03040	AUDIOLOGY	0		0	0	0	76.02
76.03	03060	WOUND CARE	0		0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	1,743,348		1,743,348	0	1,743,348	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	746,392		746,392		746,392	92.00
200.00		Subtotal (see instructions)	12,669,955	0	12,669,955	0	12,669,955	200.00
201.00		Less Observation Beds	746,392		746,392		746,392	201.00
202.00		Total (see instructions)	11,923,563	0	11,923,563	0	11,923,563	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/31/2017 8:50 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,977,051		4,977,051			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	606,078	8,421,376	9,027,454	0.191315	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	106,959	2,218,137	2,325,096	0.007505	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	195,725	4,815,838	5,011,563	0.431795	0.000000	54.00
54.01	05401	ULTRASOUND	70,700	1,677,407	1,748,107	0.076277	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	559,844	8,355,170	8,915,014	0.012873	0.000000	57.00
58.00	05800	MRI	61,239	3,659,956	3,721,195	0.081619	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,314,007	10,634,130	11,948,137	0.124454	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	31,807	78,972	110,779	0.005209	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	538,933	399,320	938,253	0.451553	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	27,970	1,105,384	1,133,354	0.541847	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,085	148,577	172,662	0.029711	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	20,027	175,999	196,026	0.045356	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	290,562	2,465,809	2,756,371	0.056027	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	220,582	304,214	524,796	0.269779	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,806	166,395	168,201	0.044274	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,874,406	5,043,529	6,917,935	0.138361	0.000000	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	0	0.000000	0.000000	76.01
76.02	03040	AUDIOLOGY	0	0	0	0.000000	0.000000	76.02
76.03	03060	WOUND CARE	0	0	0	0.000000	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	728,544	14,419,205	15,147,749	0.115090	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	195,531	1,197,826	1,393,357	0.535679	0.000000	92.00
200.00		Subtotal (see instructions)	11,845,856	65,287,244	77,133,100			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,845,856	65,287,244	77,133,100			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/31/2017 8:50 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.191315
51.00	05100	RECOVERY ROOM	0.000000
53.00	05300	ANESTHESIOLOGY	0.007505
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.431795
54.01	05401	ULTRASOUND	0.076277
56.00	05600	RADIOISOTOPE	0.000000
57.00	05700	CT SCAN	0.012873
58.00	05800	MRI	0.081619
59.00	05900	CARDIAC CATHETERIZATION	0.000000
60.00	06000	LABORATORY	0.124454
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.005209
65.00	06500	RESPIRATORY THERAPY	0.451553
66.00	06600	PHYSICAL THERAPY	0.541847
67.00	06700	OCCUPATIONAL THERAPY	0.029711
68.00	06800	SPEECH PATHOLOGY	0.045356
69.00	06900	ELECTROCARDIOLOGY	0.056027
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.269779
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.044274
73.00	07300	DRUGS CHARGED TO PATIENTS	0.138361
76.00	03020	ACUPUNCTURE	0.000000
76.01	03030	ANGIOCARDIOGRAPHY	0.000000
76.02	03040	AUDIOLOGY	0.000000
76.03	03060	WOUND CARE	0.000000
		OUTPATIENT SERVICE COST CENTERS	
90.00	09000	CLINIC	0.000000
91.00	09100	EMERGENCY	0.115090
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.535679
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/31/2017 8:50 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,919,898		1,919,898	0	1,919,898	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,727,084		1,727,084	0	1,727,084	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	17,451		17,451	0	17,451	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,163,966		2,163,966	0	2,163,966	54.00
54.01	05401	ULTRASOUND	133,341		133,341	0	133,341	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	114,761		114,761	0	114,761	57.00
58.00	05800	MRI	303,721		303,721	0	303,721	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,486,989		1,486,989	0	1,486,989	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	577		577	0	577	62.00
65.00	06500	RESPIRATORY THERAPY	423,671	0	423,671	0	423,671	65.00
66.00	06600	PHYSICAL THERAPY	614,104	0	614,104	0	614,104	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,130	0	5,130	0	5,130	67.00
68.00	06800	SPEECH PATHOLOGY	8,891	0	8,891	0	8,891	68.00
69.00	06900	ELECTROCARDIOLOGY	154,432		154,432	0	154,432	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	141,579		141,579	0	141,579	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,447		7,447	0	7,447	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	957,173		957,173	0	957,173	73.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0		0	0	0	76.01
76.02	03040	AUDIOLOGY	0		0	0	0	76.02
76.03	03060	WOUND CARE	0		0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	1,743,348		1,743,348	0	1,743,348	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	746,392		746,392		746,392	92.00
200.00		Subtotal (see instructions)	12,669,955	0	12,669,955	0	12,669,955	200.00
201.00		Less Observation Beds	746,392		746,392		746,392	201.00
202.00		Total (see instructions)	11,923,563	0	11,923,563	0	11,923,563	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/31/2017 8:50 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,977,051		4,977,051			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	606,078	8,421,376	9,027,454	0.191315	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	106,959	2,218,137	2,325,096	0.007505	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	195,725	4,815,838	5,011,563	0.431795	0.000000	54.00
54.01	05401	ULTRASOUND	70,700	1,677,407	1,748,107	0.076277	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	559,844	8,355,170	8,915,014	0.012873	0.000000	57.00
58.00	05800	MRI	61,239	3,659,956	3,721,195	0.081619	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,314,007	10,634,130	11,948,137	0.124454	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	31,807	78,972	110,779	0.005209	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	538,933	399,320	938,253	0.451553	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	27,970	1,105,384	1,133,354	0.541847	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,085	148,577	172,662	0.029711	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	20,027	175,999	196,026	0.045356	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	290,562	2,465,809	2,756,371	0.056027	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	220,582	304,214	524,796	0.269779	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,806	166,395	168,201	0.044274	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,874,406	5,043,529	6,917,935	0.138361	0.000000	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	0	0.000000	0.000000	76.01
76.02	03040	AUDIOLOGY	0	0	0	0.000000	0.000000	76.02
76.03	03060	WOUND CARE	0	0	0	0.000000	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	728,544	14,419,205	15,147,749	0.115090	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	195,531	1,197,826	1,393,357	0.535679	0.000000	92.00
200.00		Subtotal (see instructions)	11,845,856	65,287,244	77,133,100			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,845,856	65,287,244	77,133,100			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/31/2017 8:50 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.191315		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.007505		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.431795		54.00
54.01	05401	ULTRASOUND	0.076277		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.012873		57.00
58.00	05800	MRI	0.081619		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.124454		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.005209		62.00
65.00	06500	RESPIRATORY THERAPY	0.451553		65.00
66.00	06600	PHYSICAL THERAPY	0.541847		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.029711		67.00
68.00	06800	SPEECH PATHOLOGY	0.045356		68.00
69.00	06900	ELECTROCARDIOLOGY	0.056027		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.269779		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.044274		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.138361		73.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03030	ANGIOCARDIOGRAPHY	0.000000		76.01
76.02	03040	AUDIOLOGY	0.000000		76.02
76.03	03060	WOUND CARE	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.115090		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.535679		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet C Part II Date/Time Prepared: 5/31/2017 8:50 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,727,084	231,982	1,495,102	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	17,451	824	16,627	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,163,966	233,942	1,930,024	0	0	54.00
54.01	05401	ULTRASOUND	133,341	2,148	131,193	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	114,761	15,024	99,737	0	0	57.00
58.00	05800	MRI	303,721	34,409	269,312	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,486,989	69,496	1,417,493	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	577	35	542	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	423,671	34,870	388,801	0	0	65.00
66.00	06600	PHYSICAL THERAPY	614,104	65,501	548,603	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,130	777	4,353	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,891	2,951	5,940	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	154,432	16,015	138,417	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	141,579	2,616	138,963	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,447	204	7,243	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	957,173	39,290	917,883	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.01
76.02	03040	AUDIOLOGY	0	0	0	0	0	76.02
76.03	03060	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,743,348	122,957	1,620,391	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	746,392	91,829	654,563	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	10,750,057	964,870	9,785,187	0	0	200.00
201.00		Less Observation Beds	746,392	91,829	654,563	0	0	201.00
202.00		Total (line 200 minus line 201)	10,003,665	873,041	9,130,624	0	0	202.00

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

Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet C Part II Date/Time Prepared: 5/31/2017 8:50 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,727,084	9,027,454	0.191315		50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	17,451	2,325,096	0.007505		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,163,966	5,011,563	0.431795		54.00
54.01	05401	ULTRASOUND	133,341	1,748,107	0.076277		54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700	CT SCAN	114,761	8,915,014	0.012873		57.00
58.00	05800	MRI	303,721	3,721,195	0.081619		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000		59.00
60.00	06000	LABORATORY	1,486,989	11,948,137	0.124454		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	577	110,779	0.005209		62.00
65.00	06500	RESPIRATORY THERAPY	423,671	938,253	0.451553		65.00
66.00	06600	PHYSICAL THERAPY	614,104	1,133,354	0.541847		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,130	172,662	0.029711		67.00
68.00	06800	SPEECH PATHOLOGY	8,891	196,026	0.045356		68.00
69.00	06900	ELECTROCARDIOLOGY	154,432	2,756,371	0.056027		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	141,579	524,796	0.269779		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,447	168,201	0.044274		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	957,173	6,917,935	0.138361		73.00
76.00	03020	ACUPUNCTURE	0	0	0.000000		76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	0.000000		76.01
76.02	03040	AUDIOLOGY	0	0	0.000000		76.02
76.03	03060	WOUND CARE	0	0	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0.000000		90.00
91.00	09100	EMERGENCY	1,743,348	15,147,749	0.115090		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	746,392	1,393,357	0.535679		92.00
200.00		Subtotal (sum of lines 50 thru 199)	10,750,057	72,156,049			200.00
201.00		Less Observation Beds	746,392	0			201.00
202.00		Total (line 200 minus line 201)	10,003,665	72,156,049			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part I Date/Time Prepared: 5/31/2017 8:50 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	236,205	0	236,205	1,798	131.37	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
200.00	Total (lines 30-199)	236,205		236,205	1,798		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	52	6,831		30.00
31.00	INTENSIVE CARE UNIT	0	0		31.00
200.00	Total (lines 30-199)	52	6,831		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/31/2017 8:50 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	231,982	9,027,454	0.025697	190,839	4,904	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	824	2,325,096	0.000354	35,722	13	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	233,942	5,011,563	0.046680	103,821	4,846	54.00
54.01	05401	ULTRASOUND	2,148	1,748,107	0.001229	36,743	45	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	15,024	8,915,014	0.001685	317,385	535	57.00
58.00	05800	MRI	34,409	3,721,195	0.009247	24,396	226	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	69,496	11,948,137	0.005816	737,440	4,289	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	35	110,779	0.000316	18,041	6	62.00
65.00	06500	RESPIRATORY THERAPY	34,870	938,253	0.037165	336,116	12,492	65.00
66.00	06600	PHYSICAL THERAPY	65,501	1,133,354	0.057794	17,338	1,002	66.00
67.00	06700	OCCUPATIONAL THERAPY	777	172,662	0.004500	21,985	99	67.00
68.00	06800	SPEECH PATHOLOGY	2,951	196,026	0.015054	11,646	175	68.00
69.00	06900	ELECTROCARDIOLOGY	16,015	2,756,371	0.005810	182,295	1,059	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,616	524,796	0.004985	132,414	660	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	204	168,201	0.001213	1,204	1	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,290	6,917,935	0.005679	987,127	5,606	73.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	0.000000	0	0	76.01
76.02	03040	AUDIOLOGY	0	0	0.000000	0	0	76.02
76.03	03060	WOUND CARE	0	0	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	122,957	15,147,749	0.008117	396,019	3,214	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	91,829	1,393,357	0.065905	113,506	7,481	92.00
200.00		Total (lines 50-199)	964,870	72,156,049		3,664,037	46,653	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 5/31/2017 8:50 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
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	1,798	0.00	52	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0		31.00
200.00		Total (lines 30-199)	1,798		52	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/31/2017 8:50 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.01
76.02	03040	AUDIOLOGY	0	0	0	0	0	76.02
76.03	03060	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/31/2017 8:50 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	9,027,454	0.000000	0.000000	190,839	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0	2,325,096	0.000000	0.000000	35,722	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,011,563	0.000000	0.000000	103,821	54.00
54.01	05401	ULTRASOUND	0	1,748,107	0.000000	0.000000	36,743	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	8,915,014	0.000000	0.000000	317,385	57.00
58.00	05800	MRI	0	3,721,195	0.000000	0.000000	24,396	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	11,948,137	0.000000	0.000000	737,440	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	110,779	0.000000	0.000000	18,041	62.00
65.00	06500	RESPIRATORY THERAPY	0	938,253	0.000000	0.000000	336,116	65.00
66.00	06600	PHYSICAL THERAPY	0	1,133,354	0.000000	0.000000	17,338	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	172,662	0.000000	0.000000	21,985	67.00
68.00	06800	SPEECH PATHOLOGY	0	196,026	0.000000	0.000000	11,646	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,756,371	0.000000	0.000000	182,295	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	524,796	0.000000	0.000000	132,414	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	168,201	0.000000	0.000000	1,204	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,917,935	0.000000	0.000000	987,127	73.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	0.000000	0.000000	0	76.01
76.02	03040	AUDIOLOGY	0	0	0.000000	0.000000	0	76.02
76.03	03060	WOUND CARE	0	0	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	15,147,749	0.000000	0.000000	396,019	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	1,393,357	0.000000	0.000000	113,506	92.00
200.00		Total (lines 50-199)	0	72,156,049			3,664,037	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/31/2017 8:50 am

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,936,716	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	840,895	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,371,355	0		54.00
54.01	05401	ULTRASOUND	0	351,160	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	2,625,462	0		57.00
58.00	05800	MRI	0	933,540	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	2,091,117	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	48,574	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	143,749	0		65.00
66.00	06600	PHYSICAL THERAPY	0	3,063	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,631	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	6,257	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,018,859	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	143,516	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	61,540	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,569,925	0		73.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	0		76.01
76.02	03040	AUDIOLOGY	0	0	0		76.02
76.03	03060	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	2,646,422	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	516,640	0		92.00
200.00		Total (lines 50-199)	0	17,312,421	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/31/2017 8:50 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.191315	2,936,716	0	0	561,838	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.007505	840,895	0	0	6,311	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.431795	1,371,355	0	0	592,144	54.00
54.01	05401	ULTRASOUND	0.076277	351,160	0	0	26,785	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.012873	2,625,462	0	0	33,798	57.00
58.00	05800	MRI	0.081619	933,540	0	0	76,195	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.124454	2,091,117	0	0	260,248	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.005209	48,574	0	0	253	62.00
65.00	06500	RESPIRATORY THERAPY	0.451553	143,749	0	0	64,910	65.00
66.00	06600	PHYSICAL THERAPY	0.541847	3,063	0	0	1,660	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.029711	3,631	0	0	108	67.00
68.00	06800	SPEECH PATHOLOGY	0.045356	6,257	0	0	284	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056027	1,018,859	0	0	57,084	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.269779	143,516	0	0	38,718	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.044274	61,540	0	0	2,725	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.138361	1,569,925	0	28,856	217,216	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0.000000	0	0	0	0	76.01
76.02	03040	AUDIOLOGY	0.000000	0	0	0	0	76.02
76.03	03060	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.115090	2,646,422	0	0	304,577	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.535679	516,640	0	0	276,753	92.00
200.00		Subtotal (see instructions)		17,312,421	0	28,856	2,521,607	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		17,312,421	0	28,856	2,521,607	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/31/2017 8:50 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,993	73.00
76.00	03020	ACUPUNCTURE	0	0	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	76.01
76.02	03040	AUDIOLOGY	0	0	76.02
76.03	03060	WOUND CARE	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	92.00
200.00		Subtotal (see instructions)	0	3,993	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	3,993	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part I Date/Time Prepared: 5/31/2017 8:50 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	236,205	0	236,205	1,798	131.37	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
200.00	Total (lines 30-199)	236,205		236,205	1,798		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	191	25,092		30.00
31.00	INTENSIVE CARE UNIT	0	0		31.00
200.00	Total (lines 30-199)	191	25,092		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/31/2017 8:50 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	231,982	9,027,454	0.025697	189,648	4,873	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	824	2,325,096	0.000354	33,221	12	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	233,942	5,011,563	0.046680	32,397	1,512	54.00
54.01	05401	ULTRASOUND	2,148	1,748,107	0.001229	11,385	14	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	15,024	8,915,014	0.001685	89,118	150	57.00
58.00	05800	MRI	34,409	3,721,195	0.009247	16,430	152	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	69,496	11,948,137	0.005816	228,860	1,331	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	35	110,779	0.000316	788	0	62.00
65.00	06500	RESPIRATORY THERAPY	34,870	938,253	0.037165	75,670	2,812	65.00
66.00	06600	PHYSICAL THERAPY	65,501	1,133,354	0.057794	1,974	114	66.00
67.00	06700	OCCUPATIONAL THERAPY	777	172,662	0.004500	837	4	67.00
68.00	06800	SPEECH PATHOLOGY	2,951	196,026	0.015054	1,204	18	68.00
69.00	06900	ELECTROCARDIOLOGY	16,015	2,756,371	0.005810	34,150	198	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,616	524,796	0.004985	39,568	197	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	204	168,201	0.001213	602	1	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,290	6,917,935	0.005679	376,414	2,138	73.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	0.000000	0	0	76.01
76.02	03040	AUDIOLOGY	0	0	0.000000	0	0	76.02
76.03	03060	WOUND CARE	0	0	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	122,957	15,147,749	0.008117	121,606	987	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	91,829	1,393,357	0.065905	25,413	1,675	92.00
200.00		Total (lines 50-199)	964,870	72,156,049		1,279,285	16,188	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 5/31/2017 8:50 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
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	1,798	0.00	191	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0		31.00
200.00		Total (lines 30-199)	1,798		191	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/31/2017 8:50 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.01
76.02	03040	AUDIOLOGY	0	0	0	0	0	76.02
76.03	03060	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/31/2017 8:50 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	9,027,454	0.000000	0.000000	189,648	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0	2,325,096	0.000000	0.000000	33,221	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,011,563	0.000000	0.000000	32,397	54.00
54.01	05401	ULTRASOUND	0	1,748,107	0.000000	0.000000	11,385	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	8,915,014	0.000000	0.000000	89,118	57.00
58.00	05800	MRI	0	3,721,195	0.000000	0.000000	16,430	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	11,948,137	0.000000	0.000000	228,860	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	110,779	0.000000	0.000000	788	62.00
65.00	06500	RESPIRATORY THERAPY	0	938,253	0.000000	0.000000	75,670	65.00
66.00	06600	PHYSICAL THERAPY	0	1,133,354	0.000000	0.000000	1,974	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	172,662	0.000000	0.000000	837	67.00
68.00	06800	SPEECH PATHOLOGY	0	196,026	0.000000	0.000000	1,204	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,756,371	0.000000	0.000000	34,150	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	524,796	0.000000	0.000000	39,568	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	168,201	0.000000	0.000000	602	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,917,935	0.000000	0.000000	376,414	73.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	0.000000	0.000000	0	76.01
76.02	03040	AUDIOLOGY	0	0	0.000000	0.000000	0	76.02
76.03	03060	WOUND CARE	0	0	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	15,147,749	0.000000	0.000000	121,606	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	1,393,357	0.000000	0.000000	25,413	92.00
200.00		Total (lines 50-199)	0	72,156,049			1,279,285	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/31/2017 8:50 am

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0	0		76.01
76.02	03040	AUDIOLOGY	0	0	0		76.02
76.03	03060	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/31/2017 8:50 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.191315	0	0	2,301,323	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.007505	0	0	544,356	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.431795	0	0	1,175,809	0	54.00
54.01	05401	ULTRASOUND	0.076277	0	0	511,863	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.012873	0	0	2,301,077	0	57.00
58.00	05800	MRI	0.081619	0	0	777,681	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.124454	0	0	2,891,938	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.005209	0	0	3,942	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.451553	0	0	98,664	0	65.00
66.00	06600	PHYSICAL THERAPY	0.541847	0	0	325,655	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.029711	0	0	85,248	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.045356	0	0	87,457	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056027	0	0	588,682	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.269779	0	0	68,716	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.044274	0	0	50,710	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.138361	0	0	1,468,001	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0.000000	0	0	0	0	76.01
76.02	03040	AUDIOLOGY	0.000000	0	0	0	0	76.02
76.03	03060	WOUND CARE	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.115090	0	0	4,260,421	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.535679	0	0	231,717	0	92.00
200.00		Subtotal (see instructions)		0	0	17,773,260	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	17,773,260	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/31/2017 8:50 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	440,278		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	4,085		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	507,708		54.00
54.01	05401	ULTRASOUND	0	39,043		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	29,622		57.00
58.00	05800	MRI	0	63,474		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	359,913		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	21		62.00
65.00	06500	RESPIRATORY THERAPY	0	44,552		65.00
66.00	06600	PHYSICAL THERAPY	0	176,455		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,533		67.00
68.00	06800	SPEECH PATHOLOGY	0	3,967		68.00
69.00	06900	ELECTROCARDIOLOGY	0	32,982		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	18,538		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,245		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	203,114		73.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03030	ANGIOCARDIOGRAPHY	0	0		76.01
76.02	03040	AUDIOLOGY	0	0		76.02
76.03	03060	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	490,332		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	124,126		92.00
200.00		Subtotal (see instructions)	0	2,542,988		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	2,542,988		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/31/2017 8:50 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,798	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,798	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)	1,099	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)	52	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)	1,919,898	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)	1,919,898	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)	1,919,898	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,067.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	55,526	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)	55,526	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/31/2017 8:50 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	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)	633,658	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	689,184	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)	6,831	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	46,653	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	53,484	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	635,700	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)	699	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,067.80	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	746,392	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/31/2017 8:50 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	236,205	1,919,898	0.123030	746,392	91,829	90.00
91.00	Nursing School cost	0	1,919,898	0.000000	746,392	0	91.00
92.00	Allied health cost	0	1,919,898	0.000000	746,392	0	92.00
93.00	All other Medical Education	0	1,919,898	0.000000	746,392	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/31/2017 8:50 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,798	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,798	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)	1,099	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)	191	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)	1,919,898	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)	1,919,898	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)	1,919,898	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,067.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	203,950	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)	203,950	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/31/2017 8:50 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	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)	209,988	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	413,938	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)	25,092	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	16,188	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	41,280	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	372,658	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)	699	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,067.80	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	746,392	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/31/2017 8:50 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	236,205	1,919,898	0.123030	746,392	91,829	90.00
91.00	Nursing School cost	0	1,919,898	0.000000	746,392	0	91.00
92.00	Allied health cost	0	1,919,898	0.000000	746,392	0	92.00
93.00	All other Medical Education	0	1,919,898	0.000000	746,392	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/31/2017 8:50 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,123,328		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.191315	190,839	36,510	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.007505	35,722	268	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.431795	103,821	44,829	54.00
54.01	05401	ULTRASOUND	0.076277	36,743	2,803	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.012873	317,385	4,086	57.00
58.00	05800	MRI	0.081619	24,396	1,991	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.124454	737,440	91,777	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.005209	18,041	94	62.00
65.00	06500	RESPIRATORY THERAPY	0.451553	336,116	151,774	65.00
66.00	06600	PHYSICAL THERAPY	0.541847	17,338	9,395	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.029711	21,985	653	67.00
68.00	06800	SPEECH PATHOLOGY	0.045356	11,646	528	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056027	182,295	10,213	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.269779	132,414	35,723	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.044274	1,204	53	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.138361	987,127	136,580	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0.000000	0	0	76.01
76.02	03040	AUDIOLOGY	0.000000	0	0	76.02
76.03	03060	WOUND CARE	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.115090	396,019	45,578	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.535679	113,506	60,803	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,664,037	633,658	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)		3,664,037		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/31/2017 8:50 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		373,374		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.191315	189,648	36,283	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.007505	33,221	249	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.431795	32,397	13,989	54.00
54.01	05401	ULTRASOUND	0.076277	11,385	868	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.012873	89,118	1,147	57.00
58.00	05800	MRI	0.081619	16,430	1,341	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.124454	228,860	28,483	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.005209	788	4	62.00
65.00	06500	RESPIRATORY THERAPY	0.451553	75,670	34,169	65.00
66.00	06600	PHYSICAL THERAPY	0.541847	1,974	1,070	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.029711	837	25	67.00
68.00	06800	SPEECH PATHOLOGY	0.045356	1,204	55	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056027	34,150	1,913	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.269779	39,568	10,675	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.044274	602	27	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.138361	376,414	52,081	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03030	ANGIOCARDIOGRAPHY	0.000000	0	0	76.01
76.02	03040	AUDIOLOGY	0.000000	0	0	76.02
76.03	03060	WOUND CARE	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.115090	121,606	13,996	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.535679	25,413	13,613	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,279,285	209,988	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,279,285		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0102	Period: From 03/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/31/2017 8:50 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	857,929	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	367,684	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)	0	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	47.72	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	7.07	30.00
31.00	Percentage of Medicaid patient days (see instructions)	17.38	31.00
32.00	Sum of lines 30 and 31	24.45	32.00
33.00	Allowable disproportionate share percentage (see instructions)	9.39	33.00
34.00	Disproportionate share adjustment (see instructions)	28,772	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0102	Period: From 03/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/31/2017 8:50 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	71,284	58,647	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	41,680	14,782	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	56,462		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)	1,310,847		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	306,672		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	1,310,847	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	98,301	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	1,409,148	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	1,409,148	61.00
62.00	Deductibles billed to program beneficiaries	175,168	62.00
63.00	Coinsurance billed to program beneficiaries	2,898	63.00
64.00	Allowable bad debts (see instructions)	13,223	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	8,595	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	13,223	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	1,239,677	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	VALUE BASED PURCH. & READMISSION ADJ	3,957	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)	0	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0102	Period: From 03/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/31/2017 8:50 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2016	195,002	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2017	111,670	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)		1,550,306	71.00
71.01	Sequestration adjustment (see instructions)		31,006	71.01
72.00	Interim payments		1,515,280	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)		4,020	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,271,244	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)	1.0053960754	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)	1.0000	0.9994	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0102	Period: From 03/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/31/2017 8:50 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,993	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	2,521,607	2.00
3.00	PPS payments	2,568,970	3.00
4.00	Outlier payment (see instructions)	62,586	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)	3,993	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	28,856	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)	28,856	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)	28,856	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	24,863	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)	3,993	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)	2,631,556	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	111	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	558,511	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)	2,076,927	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)	2,076,927	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,076,927	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)	72,404	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	47,063	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	72,404	36.00
37.00	Subtotal (see instructions)	2,123,990	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)	2,123,990	40.00
40.01	Sequestration adjustment (see instructions)	42,480	40.01
41.00	Interim payments	2,033,131	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	48,379	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: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2017 8:50 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,515,280		2,033,131	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)		1,515,280		2,033,131	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		4,020		48,379	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,519,300		2,081,510	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: 15-0102 | Component CCN: 15-U102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/31/2017 8:50 am

Title XVIII | Swing Beds - SNF | PPS

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0102	Period: From 03/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/31/2017 8:50 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-0102 Component CCN: 15-U102	Period: From 03/01/2016 To 12/31/2016	Worksheet E-2 Date/Time Prepared: 5/31/2017 8:50 am
	Title XVIII	Swing Beds - SNF	PPS

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

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

Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 5/31/2017 8:50 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	655	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,267,701	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-802,364	0	0	0	6.00
7.00	Inventory	474,858	0	0	0	7.00
8.00	Prepaid expenses	198,643	0	0	0	8.00
9.00	Other current assets	224,686	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)	7,364,179	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	-3,700	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	-51,530	0	0	0	16.00
17.00	Leasehold improvements	71,206	0	0	0	17.00
18.00	Accumulated depreciation	-434,642	0	0	0	18.00
19.00	Fixed equipment	3,944	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	3,395,985	0	0	0	23.00
24.00	Accumulated depreciation	-894,851	0	0	0	24.00
25.00	Minor equipment depreciable	25,027	0	0	0	25.00
26.00	Accumulated depreciation	-125	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)	2,111,314	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	72,212	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	72,212	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	9,547,705	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	407,901	0	0	0	37.00
38.00	Salaries, wages, and fees payable	525,426	0	0	0	38.00
39.00	Payroll taxes payable	61,737	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	3,693,490	0	0	0	43.00
44.00	Other current liabilities	186,124	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,874,678	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,592	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,592	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,878,270	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	4,669,435				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)	4,669,435	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	9,547,705	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 5/31/2017 8:50 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		15,500,063		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,669,437				2.00
3.00	Total (sum of line 1 and line 2)		20,169,500		0		3.00
4.00		0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		20,169,500		0		11.00
12.00	ENDING FUND BALANCE PER PROIR OWNER	15,500,063		0		0	12.00
13.00	ROUNDING	2		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)		15,500,065		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		4,669,435		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			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	ENDING FUND BALANCE PER PROIR OWNER		0			12.00
13.00	ROUNDING		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: 15-0102 | Period: From 03/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/31/2017 8:50 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,088,774		5,088,774	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,088,774		5,088,774	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,088,774		5,088,774	17.00
18.00	Ancillary services	6,757,081	0	6,757,081	18.00
19.00	Outpatient services	0	60,386,564	60,386,564	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER REVENUE	0	4,900,680	4,900,680	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,845,855	65,287,244	77,133,099	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		16,238,863		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)		16,238,863		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0102	Period: From 03/01/2016 To 12/31/2016	Worksheet G-3 Date/Time Prepared: 5/31/2017 8:50 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	77,133,099	1.00
2.00	Less contractual allowances and discounts on patients' accounts	56,499,669	2.00
3.00	Net patient revenues (line 1 minus line 2)	20,633,430	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	16,238,863	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,394,567	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	274,870	24.00
25.00	Total other income (sum of lines 6-24)	274,870	25.00
26.00	Total (line 5 plus line 25)	4,669,437	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)	4,669,437	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0102	Period: From 03/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 5/31/2017 8:50 am
	Title XVIII	Hospital	PPS

			1.00	
	PART I - FULLY PROSPECTIVE METHOD			
	CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier		98,301	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		0	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)		3.59	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		98,301	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