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: 15-0104	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/26/2017 10:50 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/26/2017 Time: 10:50 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 WITHAM MEMORIAL HOSPITAL (15-0104) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	43,014	82,288	0	26,686	1.00
2.00	Subprovider - IPF	0	2	-203		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	-26		0	7.00
200.00	Total	0	43,016	82,059	0	26,686	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2017 10:44 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2605 N. LEBANON STREET	PO Box:			1.00
2.00	City: LEBANON	State: IN	Zip Code: 46052-	County: BOONE	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	WITHAM MEMORIAL HOSPITAL	150104	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	WITHAM HOSPITAL GEROPSYCH	15S104	26900	4	01/01/2000	N	P	N	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	WITHAM HOSPITAL ECU	155832	26900		05/07/2015	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	176	737	0	0	1,128	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: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2017 10:44 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	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)				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: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2017 10:44 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: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2017 10:44 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.	Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N		0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	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	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	149,584	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2017 10:44 am

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0104	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/26/2017 10:44 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2014	09/30/2015	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: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2017 10:44 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	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	03/07/2017	Y	03/07/2017	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: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 5/26/2017 10:44 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		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.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		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.		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		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		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.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA	SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946	TSEVERS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0104	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/26/2017 10:44 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		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: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/26/2017 10:44 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	60	21,960	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)		60	21,960	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,928	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		68	24,888	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3,660		0	16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY	44.00	18	6,588		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		96				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: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2017 10:44 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,274	171	5,104			1.00
2.00	HMO and other (see instructions)	482	1,819				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,274	171	5,104			7.00
8.00	INTENSIVE CARE UNIT	847	0	1,683			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		0	993			13.00
14.00	Total (see instructions)	3,121	171	7,780	0.00	623.03	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,338	0	2,755	0.00	19.62	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	3,286	0	4,390	0.00	17.99	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	660.64	27.00
28.00	Observation Bed Days		0	1,154			28.00
29.00	Ambulance Trips	1,715					29.00
30.00	Employee discount days (see instruction)			140			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	51	81			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: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2017 10:44 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	920	27	2,289	1.00
2.00	HMO and other (see instructions)			159	454		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	920	27	2,289	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	182	0	227	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 5/26/2017 10:44 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	51,543,102	2,694,884	54,237,986	1,374,122.00	39.47	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	852,873	14,177	867,050	37,421.00	23.17	9.00
10.00	Excluded area salaries (see instructions)		20,513,360	1,857,458	22,370,818	480,929.00	46.52	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,715,267	0	1,715,267	21,696.00	79.06	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		11,172,172	0	11,172,172			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		6,445,789	0	6,445,789			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		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

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 5/26/2017 10:44 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	
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	631,700	11,555	643,255	11,144.00	57.72	26.00
27.00	Administrative & General	5.00	10,367,016	349,720	10,716,736	183,201.00	58.50	27.00
28.00	Administrative & General under contract (see inst.)		665,183	0	665,183	7,545.00	88.16	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	563,679	9,288	572,967	21,236.00	26.98	30.00
31.00	Laundry & Linen Service	8.00	22,392	578	22,970	1,995.00	11.51	31.00
32.00	Housekeeping	9.00	380,134	8,708	388,842	29,100.00	13.36	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	722,169	-306,295	415,874	21,005.00	19.80	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	321,457	321,457	22,358.00	14.38	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	526,093	16,762	542,855	12,554.00	43.24	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	427,478	8,389	435,867	13,203.00	33.01	40.00
41.00	Medical Records & Medical Records Library	16.00	1,010,703	21,913	1,032,616	40,339.00	25.60	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part III Date/Time Prepared: 5/26/2017 10:44 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)		52,208,285	2,694,884	54,903,169	1,381,667.00	39.74	1.00
2.00	Excluded area salaries (see instructions)		21,366,233	1,871,635	23,237,868	518,350.00	44.83	2.00
3.00	Subtotal salaries (line 1 minus line 2)		30,842,052	823,249	31,665,301	863,317.00	36.68	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,715,267	0	1,715,267	21,696.00	79.06	4.00
5.00	Subtotal wage-related costs (see inst.)		11,172,172	0	11,172,172	0.00	35.28	5.00
6.00	Total (sum of lines 3 thru 5)		43,729,491	823,249	44,552,740	885,013.00	50.34	6.00
7.00	Total overhead cost (see instructions)		15,316,547	442,075	15,758,622	363,680.00	43.33	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part IV Date/Time Prepared: 5/26/2017 10:44 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	2,076,818	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)	9,959,226	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	1,565,569	9.00
10.00	Dental, Hearing and Vision Plan	387,252	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	98,451	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	172,657	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	314,497	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	3,038,157	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	5,334	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	17,617,961	24.00
	Part B - Other than Core Related Cost		
25.00	EMPLOYEE RECOGNITION	132,604	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part V | Date/Time Prepared: 5/26/2017 10:44 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	1,715,267	17,617,961	1.00
2.00	Hospital	1,715,267	17,617,961	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-7 | Date/Time Prepared: 5/26/2017 10:44 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.			2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	23	0	23	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	36	0	36	5.00
6.00		RVL	6	0	6	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	5	0	5	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	223	0	223	12.00
13.00		RUB	148	0	148	13.00
14.00		RUA	312	0	312	14.00
15.00		RVC	603	0	603	15.00
16.00		RVB	303	0	303	16.00
17.00		RVA	843	0	843	17.00
18.00		RHC	224	0	224	18.00
19.00		RHB	122	0	122	19.00
20.00		RHA	185	0	185	20.00
21.00		RMC	30	0	30	21.00
22.00		RMB	6	0	6	22.00
23.00		RMA	27	0	27	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	5	0	5	32.00
33.00		HC2	8	0	8	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	19	0	19	35.00
36.00		HB1	101	0	101	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	11	0	11	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	6	0	6	46.00
47.00		CD2	10	0	10	47.00
48.00		CD1	9	0	9	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	6	0	6	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	5	0	5	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-7 | Date/Time Prepared: 5/26/2017 10:44 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	10	0	10	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		3,286	0	3,286	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	26900	26900	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	2,210,215			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 5/26/2017 10:44 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)	0.215116	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	10,988,880	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	48,448,756	6.00
7.00	Medicaid cost (line 1 times line 6)	10,422,103	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)	0	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)	0	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)	2,278,925	0	2,278,925	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	490,233	0	490,233	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	490,233	0	490,233	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?		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)	11,472,529	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	149,003	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	11,323,526	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,435,872	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,926,105	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,926,105	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/26/2017 10:44 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		5,107,885	5,107,885	299,817	5,407,702	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	3,087,919	3,087,919	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	631,700	14,625,541	15,257,241	-2,383,708	12,873,533	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,367,016	11,012,898	21,379,914	-1,323,148	20,056,766	5.00
7.00	00700	OPERATION OF PLANT	563,679	2,557,618	3,121,297	-70,801	3,050,496	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,392	281,989	304,381	495	304,876	8.00
9.00	00900	HOUSEKEEPING	380,134	203,319	583,453	6,631	590,084	9.00
10.00	01000	DIETARY	722,169	809,258	1,531,427	-753,716	777,711	10.00
11.00	01100	CAFETERIA	0	0	0	760,777	760,777	11.00
13.00	01300	NURSING ADMINISTRATION	526,093	87,516	613,609	-26,878	586,731	13.00
15.00	01500	PHARMACY	427,478	2,459,665	2,887,143	-1,819,711	1,067,432	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,010,703	328,353	1,339,056	15,968	1,355,024	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,818,749	1,121,567	3,940,316	-239,932	3,700,384	30.00
31.00	03100	INTENSIVE CARE UNIT	1,003,831	528,629	1,532,460	-120,556	1,411,904	31.00
40.00	04000	SUBPROVIDER - IPF	1,109,822	256,397	1,366,219	1,843	1,368,062	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	2,720	2,720	0	2,720	43.00
44.00	04400	SKILLED NURSING FACILITY	852,873	458,681	1,311,554	-85,566	1,225,988	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,906,585	6,922,716	8,829,301	-5,629,288	3,200,013	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,128,913	1,712,971	2,841,884	-171,212	2,670,672	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	329,163	123,273	452,436	-717	451,719	55.01
57.00	05700	CT SCAN	160,591	566,714	727,305	-8,872	718,433	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	274,001	892,437	1,166,438	-299,582	866,856	58.00
59.00	05900	CARDIAC CATHETERIZATION	129,776	540,587	670,363	-241,011	429,352	59.00
60.00	06000	LABORATORY	2,009,307	4,011,794	6,021,101	-149,468	5,871,633	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	75,747	75,747	0	75,747	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,434,808	250,244	1,685,052	16,923	1,701,975	66.00
67.00	06700	OCCUPATIONAL THERAPY	331,247	35,198	366,445	7,527	373,972	67.00
67.01	06701	AUDIOLOGY	186,187	222,636	408,823	-13,035	395,788	67.01
68.00	06800	SPEECH PATHOLOGY	108,062	8,331	116,393	1,969	118,362	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	861,498	250,239	1,111,737	-53,661	1,058,076	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-12,913	-12,913	2,593,514	2,580,601	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	3,824,332	3,824,332	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,761,685	1,761,685	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	174,215	121,237	295,452	-8,157	287,295	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	1,754	1,754	0	1,754	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	4,547	4,547	-1,332	3,215	90.05
90.07	09007	UROLOGY CLINIC	0	6,306	6,306	-2,727	3,579	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	798	8,265	9,063	2,395	11,458	90.09
90.11	09011	NEUROLOGY CLINIC	0	34	34	0	34	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	46,465	46,465	-41,086	5,379	90.12
90.13	09013	ALLERGY CLINIC	100,905	37,261	138,166	140	138,306	90.13
90.14	09014	WOUND CARE	296,730	246,584	543,314	-39,524	503,790	90.14
91.00	09100	EMERGENCY	2,270,139	2,177,639	4,447,778	-367,017	4,080,761	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,487,957	449,220	1,937,177	-134,804	1,802,373	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	33,627,521	58,541,322	92,168,843	-1,603,574	90,565,269	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,616,092	7,919,275	25,535,367	1,602,151	27,137,518	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0	0	0	194.01
194.02	07952	BOUTIQUE SERVICES	66,035	101,776	167,811	586	168,397	194.02
194.03	07953	RETAIL PHARMACY	233,454	1,535,555	1,769,009	837	1,769,846	194.03
200.00		TOTAL (SUM OF LINES 118-199)	51,543,102	68,097,928	119,641,030	0	119,641,030	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/26/2017 10:44 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-92,020	5,315,682		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	3,087,919		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-5,244,324	7,629,209		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,315,423	15,741,343		5.00
7.00	00700	OPERATION OF PLANT	0	3,050,496		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	304,876		8.00
9.00	00900	HOUSEKEEPING	0	590,084		9.00
10.00	01000	DIETARY	-286,414	491,297		10.00
11.00	01100	CAFETERIA	0	760,777		11.00
13.00	01300	NURSING ADMINISTRATION	0	586,731		13.00
15.00	01500	PHARMACY	0	1,067,432		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-181	1,354,843		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,700,384		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,411,904		31.00
40.00	04000	SUBPROVIDER - IPF	-34,318	1,333,744		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	2,720		43.00
44.00	04400	SKILLED NURSING FACILITY	-2,600	1,223,388		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-754,367	2,445,646		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-54	2,670,618		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	451,719		55.01
57.00	05700	CT SCAN	0	718,433		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	866,856		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	429,352		59.00
60.00	06000	LABORATORY	-251,000	5,620,633		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	75,747		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	1,701,975		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	373,972		67.00
67.01	06701	AUDIOLOGY	-238,055	157,733		67.01
68.00	06800	SPEECH PATHOLOGY	0	118,362		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	0	1,058,076		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-107,844	2,472,757		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,824,332		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,761,685		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	287,295		90.01
90.02	09002	CLINIC	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	-1,754	0		90.03
90.04	09004	ENT CLINIC	0	0		90.04
90.05	09005	SURGERY CLINIC	-3,215	0		90.05
90.07	09007	UROLOGY CLINIC	-3,579	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	-11,458	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	34		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	5,379		90.12
90.13	09013	ALLERGY CLINIC	0	138,306		90.13
90.14	09014	WOUND CARE	0	503,790		90.14
91.00	09100	EMERGENCY	-1,376,750	2,704,011		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-95	1,802,278		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-12,723,451	77,841,818		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	27,137,518		192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0		194.00
194.01	07951	CAFE/BOUTIQUE	0	0		194.01
194.02	07952	BOUTIQUE SERVICES	0	168,397		194.02
194.03	07953	RETAIL PHARMACY	0	1,769,846		194.03
200.00		TOTAL (SUM OF LINES 118-199)	-12,723,451	106,917,579		200.00

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		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	302,566		1.00
	TOTALS		0	302,566		
	B - INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	614,243		1.00
	TOTALS		0	614,243		
	C - CAFETERIA					
1.00	CAFETERIA	11.00	321,457	439,320		1.00
	TOTALS		321,457	439,320		
	D - MME DEPRECIATION					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	3,087,919		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
38.00		0.00	0	0		38.00
	TOTALS		0	3,087,919		
	E - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,815,415		1.00
	TOTALS		0	1,815,415		
	F - MED SUPPLY IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	3,824,332		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
	TOTALS		0	3,824,332		
	G - CHARGABLE MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,599,099		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00

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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	TOTALS		0	2,599,099	
	H - BONUS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	11,555	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	349,720	0	2.00
3.00	OPERATION OF PLANT	7.00	9,288	0	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	578	0	4.00
5.00	HOUSEKEEPING	9.00	8,708	0	5.00
6.00	DIETARY	10.00	15,162	0	6.00
7.00	NURSING ADMINISTRATION	13.00	16,762	0	7.00
8.00	PHARMACY	15.00	8,389	0	8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	21,913	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	70,691	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	20,356	0	11.00
12.00	SUBPROVIDER - IPF	40.00	28,771	0	12.00
13.00	SKILLED NURSING FACILITY	44.00	14,177	0	13.00
14.00	OPERATING ROOM	50.00	46,274	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	36,829	0	15.00
16.00	ULTRA SOUND	55.01	7,395	0	16.00
17.00	CT SCAN	57.00	4,053	0	17.00
18.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	6,912	0	18.00
19.00	CARDIAC CATHETERIZATION	59.00	5,354	0	19.00
20.00	LABORATORY	60.00	51,596	0	20.00
21.00	PHYSICAL THERAPY	66.00	32,855	0	21.00
22.00	OCCUPATIONAL THERAPY	67.00	8,181	0	22.00
23.00	AUDIOLOGY	67.01	4,045	0	23.00
24.00	SPEECH PATHOLOGY	68.00	2,033	0	24.00
25.00	CARDIOLOGY	69.01	18,664	0	25.00
26.00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	4,044	0	26.00
27.00	GASTROENTEROLOGY CLINIC	90.09	2,395	0	27.00
28.00	ALLERGY CLINIC	90.13	1,709	0	28.00
29.00	WOUND CARE	90.14	5,174	0	29.00
30.00	EMERGENCY	91.00	52,614	0	30.00
31.00	AMBULANCE SERVICES	95.00	32,550	0	31.00
32.00	PHYSICIANS' PRIVATE OFFICES	192.00	1,792,001	0	32.00
33.00	BOUTIQUE SERVICES	194.02	1,495	0	33.00
34.00	RETAIL PHARMACY	194.03	2,641	0	34.00
	TOTALS		2,694,884	0	
500.00	Grand Total: Increases		3,016,341	12,682,894	500.00

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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	302,566	0		1.00
	TOTALS		0	302,566			
	B - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	614,243	12		1.00
	TOTALS		0	614,243			
	C - CAFETERIA						
1.00	DIETARY	10.00	321,457	439,320	0		1.00
	TOTALS		321,457	439,320			
	D - MME DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	314,426	9		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,945	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	756,059	0		3.00
4.00	OPERATION OF PLANT	7.00	0	80,089	0		4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	0	83	0		5.00
6.00	HOUSEKEEPING	9.00	0	2,077	0		6.00
7.00	DIETARY	10.00	0	7,924	0		7.00
8.00	NURSING ADMINISTRATION	13.00	0	43,640	0		8.00
9.00	PHARMACY	15.00	0	1,963	0		9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	5,945	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	95,056	0		11.00
12.00	INTENSIVE CARE UNIT	31.00	0	32,953	0		12.00
13.00	SUBPROVIDER - IPF	40.00	0	3,578	0		13.00
15.00	SKILLED NURSING FACILITY	44.00	0	66,414	0		15.00
16.00	OPERATING ROOM	50.00	0	267,178	0		16.00
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	181,100	0		17.00
18.00	ULTRA SOUND	55.01	0	2,541	0		18.00
19.00	CT SCAN	57.00	0	712	0		19.00
20.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	302,134	0		20.00
21.00	CARDIAC CATHETERIZATION	59.00	0	151,841	0		21.00
22.00	LABORATORY	60.00	0	187,972	0		22.00
23.00	PHYSICAL THERAPY	66.00	0	13,029	0		23.00
24.00	OCCUPATIONAL THERAPY	67.00	0	645	0		24.00
25.00	AUDIOLOGY	67.01	0	17,074	0		25.00
26.00	SPEECH PATHOLOGY	68.00	0	64	0		26.00
27.00	CARDIOLOGY	69.01	0	66,903	0		27.00
28.00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	0	6,813	0		28.00
29.00	SURGERY CLINIC	90.05	0	1,332	0		29.00
30.00	UROLOGY CLINIC	90.07	0	2,538	0		30.00
31.00	OPTHAMOLOGY CLINIC	90.12	0	41,086	0		31.00
32.00	ALLERGY CLINIC	90.13	0	1,237	0		32.00
33.00	WOUND CARE	90.14	0	21,209	0		33.00
34.00	EMERGENCY	91.00	0	76,078	0		34.00
35.00	AMBULANCE SERVICES	95.00	0	152,990	0		35.00
36.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	177,578	0		36.00
37.00	BOUTIQUE SERVICES	194.02	0	909	0		37.00
38.00	RETAIL PHARMACY	194.03	0	1,804	0		38.00
	TOTALS		0	3,087,919			
	E - DRUGS						
1.00	PHARMACY	15.00	0	1,815,415	0		1.00
	TOTALS		0	1,815,415			
	F - MED SUPPLY IMPLANTS						
1.00	OPERATING ROOM	50.00	0	3,657,671	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	21,209	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	84,988	0		3.00
4.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,585	0		4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	53,730	0		5.00
6.00	WOUND CARE	90.14	0	1,149	0		6.00
	TOTALS		0	3,824,332			
	G - CHARGABLE MED SUPPLIES						
1.00	DIETARY	10.00	0	177	0		1.00
2.00	PHARMACY	15.00	0	10,722	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	215,567	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	107,959	0		4.00
5.00	SUBPROVIDER - IPF	40.00	0	23,350	0		5.00
6.00	SKILLED NURSING FACILITY	44.00	0	33,329	0		6.00
7.00	OPERATING ROOM	50.00	0	1,750,713	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,732	0		8.00
9.00	ULTRA SOUND	55.01	0	5,571	0		9.00
10.00	CT SCAN	57.00	0	12,213	0		10.00

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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
11.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	4,360	0		11.00
12.00	CARDIAC CATHETERIZATION	59.00	0	9,536	0		12.00
13.00	LABORATORY	60.00	0	13,092	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	2,903	0		14.00
15.00	OCCUPATIONAL THERAPY	67.00	0	9	0		15.00
16.00	AUDIOLOGY	67.01	0	6	0		16.00
17.00	CARDIOLOGY	69.01	0	5,422	0		17.00
18.00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	0	5,388	0		18.00
19.00	UROLOGY CLINIC	90.07	0	189	0		19.00
20.00	ALLERGY CLINIC	90.13	0	332	0		20.00
21.00	WOUND CARE	90.14	0	22,340	0		21.00
22.00	EMERGENCY	91.00	0	343,553	0		22.00
23.00	AMBULANCE SERVICES	95.00	0	14,364	0		23.00
24.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	12,272	0		24.00
	TOTALS		0	2,599,099			
	H - BONUS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,694,884	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
31.00		0.00	0	0	0		31.00
32.00		0.00	0	0	0		32.00
33.00		0.00	0	0	0		33.00
34.00		0.00	0	0	0		34.00
	TOTALS		0	2,694,884			
500.00	Grand Total: Decreases		321,457	15,377,778			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 5/26/2017 10:44 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	15,081,204	187,970	0	187,970	34,651	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	83,152,207	739,356	0	739,356	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,240,495	0	0	0	169,293	5.00
6.00	Movable Equipment	47,274,222	5,209,591	0	5,209,591	258,387	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	147,748,128	6,136,917	0	6,136,917	462,331	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	147,748,128	6,136,917	0	6,136,917	462,331	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	15,234,523	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	83,891,563	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	2,071,202	0	5.00
6.00	Movable Equipment	52,225,426	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	153,422,714	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	153,422,714	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part II Date/Time Prepared: 5/26/2017 10:44 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	5,107,885	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,107,885	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	5,107,885		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	5,107,885		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 5/26/2017 10:44 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	83,856,912	0	83,856,912	0.975896	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,071,202	0	2,071,202	0.024104	0	2.00
3.00	Total (sum of lines 1-2)	85,928,114	0	85,928,114	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	4,758,412	-56,973	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	3,087,919	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	7,846,331	-56,973	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	614,243	0	0	5,315,682	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	3,087,919	2.00
3.00	Total (sum of lines 1-2)	0	614,243	0	0	8,403,601	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/26/2017 10:44 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	B	-5,106	ADMINISTRATIVE & GENERAL	5.00	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	-2,419,035			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-221,614	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,792	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/26/2017 10:44 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	HOSPITAL ADMINISTRAT SPONSORSHIPS/DO	A	-4,250	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	LEASE INCOME	B	-11,500	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.01
33.02	RENTAL REVENUE	B	-35,273	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.02
33.03	1208 N LEBANON RENTAL INCOME	B	-10,200	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.03
33.04	WELLNESS REVENUE	B	-62,726	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	MEDICAL STAFF FEES	B	-5,900	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	VOLUNTEER MISC REVENUE	B	-8,092	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PATIENT ACCOUNTS	B	-955	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MISC INCOME RECEIVED	B	-785	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	MEALS ON WHEELS	B	-47,948	DIETARY	10.00	0	33.09
33.10	HEAD START & CASH(SHORT) OVER	B	-11,378	DIETARY	10.00	0	33.10
33.11	CASH(SHORT) OVER	B	118	DIETARY	10.00	0	33.11
33.12	CICOA MEAL VOUCHERS	B	-3,800	DIETARY	10.00	0	33.12
33.13	MEDICAL RECORDS	B	-181	MEDICAL RECORDS & LIBRARY	16.00	0	33.13
33.14	RADIOLOGY DIAGNOSTIC-PURCHASING DISC	B	-54	RADIOLOGY-DIAGNOSTIC	54.00	0	33.14
33.15	CENTRAL SUPPLY PURCHASING DISCOUNTS	B	-107,844	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.15
33.16	AMBULANCE	B	-95	AMBULANCE SERVICES	95.00	0	33.16
33.17	DERMATOLOGY CLINIC RENT	A	-1,754	DERMATOLOGY CLINIC	90.03	0	33.17
33.18	SURGERY CLINIC RENT	A	-3,215	SURGERY CLINIC	90.05	0	33.18
33.19	UROLOGY CLINIC RENT	A	-3,579	UROLOGY CLINIC	90.07	0	33.19
33.20	GASTROENTEROLOGY CLINIC RENT	A	-11,458	GASTROENTEROLOGY CLINIC	90.09	0	33.20
33.21	2010 PREMIUM AMORTIZATION	B	-24,133	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.21
33.22	2010 BOND INTEREST ON INVEST	B	-3,772	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.22
33.23	2015 BOND INTEREST ON INVEST	B	-7,142	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.23
33.24	VOLUNTEER REVENUE INTEREST	B	-57	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	GAIN/(LOSS) CIHA	B	-1,112,905	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	GAIN/(LOSS) SHO SPC	B	-508,826	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	GAIN/(LOSS) SHO RRG	B	-324	ADMINISTRATIVE & GENERAL	5.00	0	33.27
33.28	LOBBYING EXPENSE-IHA DUES	A	-1,797	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	LOBBYING EXPENSE-AHA DUES	A	-3,994	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	NON-REIMBURSABLE ADVERTISING COSTS	A	-256,418	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	SELF INSURANCE CLAIMS PAID	B	-5,181,598	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.31
33.32	HAF FEE	A	-1,923,574	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	EMPLOYEE HEALTH REV CLIENT	B	-88,372	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	EDUCATION REVENUE	B	-3,561	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35	BANK FEES	A	-195,271	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36	GAIN/(LOSS) ON INVESTMENTS	B	542,097	ADMINISTRATIVE & GENERAL	5.00	0	33.36
33.37	INTEREST ON INVESTMENTS	B	-737,333	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.38	HEARING AID COSTS	A	-238,055	AUDIOLOGY	67.01	0	33.38
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-12,723,451				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 5/26/2017 10:44 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	40.00	SUBPROVIDER - IPF	120,000	0	120,000	181,300	983	1.00
2.00	44.00	SKILLED NURSING FACILITY	2,600	2,600	0	0	0	2.00
3.00	91.00	EMERGENCY	300,000	300,000	0	0	0	3.00
4.00	91.00	EMERGENCY	1,076,750	1,076,750	0	0	0	4.00
5.00	50.00	OPERATING ROOM	754,367	754,367	0	0	0	5.00
6.00	60.00	LABORATORY	251,000	251,000	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,504,717	2,384,717	120,000		983	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	40.00	SUBPROVIDER - IPF	85,682	4,284	0	0	0	1.00
2.00	44.00	SKILLED NURSING FACILITY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			85,682	4,284	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	40.00	SUBPROVIDER - IPF	0	85,682	34,318	34,318		1.00
2.00	44.00	SKILLED NURSING FACILITY	0	0	0	2,600		2.00
3.00	91.00	EMERGENCY	0	0	0	300,000		3.00
4.00	91.00	EMERGENCY	0	0	0	1,076,750		4.00
5.00	50.00	OPERATING ROOM	0	0	0	754,367		5.00
6.00	60.00	LABORATORY	0	0	0	251,000		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	85,682	34,318	2,419,035		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/26/2017 10:44 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	5,315,682	5,315,682				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	3,087,919		3,087,919			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,629,209	12,089	7,023	7,648,321		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,741,343	386,358	224,438	1,529,353	17,881,492	5.00
7.00	00700	OPERATION OF PLANT	3,050,496	506,170	294,038	81,766	3,932,470	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	304,876	0	0	3,278	308,154	8.00
9.00	00900	HOUSEKEEPING	590,084	58,286	33,859	55,490	737,719	9.00
10.00	01000	DIETARY	491,297	130,468	75,790	59,348	756,903	10.00
11.00	01100	CAFETERIA	760,777	0	0	45,874	806,651	11.00
13.00	01300	NURSING ADMINISTRATION	586,731	0	0	77,469	664,200	13.00
15.00	01500	PHARMACY	1,067,432	40,277	23,397	62,201	1,193,307	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,354,843	63,624	36,960	147,362	1,602,789	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,700,384	423,187	245,832	412,343	4,781,746	30.00
31.00	03100	INTENSIVE CARE UNIT	1,411,904	116,219	67,512	146,159	1,741,794	31.00
40.00	04000	SUBPROVIDER - IPF	1,333,744	133,065	77,298	162,485	1,706,592	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	2,720	0	0	0	2,720	43.00
44.00	04400	SKILLED NURSING FACILITY	1,223,388	100,765	58,535	123,734	1,506,422	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,445,646	337,752	196,202	278,687	3,258,287	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,670,618	413,071	239,956	166,360	3,490,005	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	451,719	0	0	48,029	499,748	55.01
57.00	05700	CT SCAN	718,433	0	0	23,496	741,929	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	866,856	35,437	20,586	40,088	962,967	58.00
59.00	05900	CARDIAC CATHETERIZATION	429,352	29,870	17,352	19,284	495,858	59.00
60.00	06000	LABORATORY	5,620,633	192,639	111,905	294,105	6,219,282	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	75,747	0	0	0	75,747	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,701,975	186,449	108,310	209,446	2,206,180	66.00
67.00	06700	OCCUPATIONAL THERAPY	373,972	0	0	48,439	422,411	67.00
67.01	06701	AUDIOLOGY	157,733	0	0	27,147	184,880	67.01
68.00	06800	SPEECH PATHOLOGY	118,362	0	0	15,711	134,073	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	1,058,076	19,214	11,162	125,605	1,214,057	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,472,757	0	0	0	2,472,757	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,824,332	0	0	0	3,824,332	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,761,685	0	0	0	1,761,685	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	287,295	79,390	46,118	25,439	438,242	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	456	456	90.09
90.11	09011	NEUROLOGY CLINIC	34	0	0	0	34	90.11
90.12	09012	OPTHAMOLOGY CLINIC	5,379	0	0	0	5,379	90.12
90.13	09013	ALLERGY CLINIC	138,306	0	0	14,644	152,950	90.13
90.14	09014	WOUND CARE	503,790	72,785	42,281	43,084	661,940	90.14
91.00	09100	EMERGENCY	2,704,011	510,283	296,427	331,473	3,842,194	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,802,278	98,874	57,437	216,987	2,175,576	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	77,841,818	3,946,272	2,292,418	4,835,342	72,863,928	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	12,962	7,530	0	20,492	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	27,137,518	891,987	518,162	2,769,650	31,317,317	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	29,413	17,086	0	46,499	194.01
194.02	07952	BOUTIQUE SERVICES	168,397	426,739	247,896	9,637	852,669	194.02
194.03	07953	RETAIL PHARMACY	1,769,846	8,309	4,827	33,692	1,816,674	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/26/2017 10:44 am

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
202.00	TOTAL (sum lines 118-201)	106,917,579	5,315,682	3,087,919	7,648,321	106,917,579	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/26/2017 10:44 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,881,492					5.00
7.00	00700	OPERATION OF PLANT	789,774	4,722,244				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	61,888	0	370,042			8.00
9.00	00900	HOUSEKEEPING	148,159	72,087	0	957,965		9.00
10.00	01000	DIETARY	152,012	161,362	0	59,397	1,129,674	10.00
11.00	01100	CAFETERIA	162,003	0	0	19,804	0	11.00
13.00	01300	NURSING ADMINISTRATION	133,394	0	0	8,955	0	13.00
15.00	01500	PHARMACY	239,657	49,814	0	18,082	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	321,895	78,690	0	39,607	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	960,337	523,392	19,088	300,885	421,428	30.00
31.00	03100	INTENSIVE CARE UNIT	349,811	143,738	4,597	79,903	136,763	31.00
40.00	04000	SUBPROVIDER - IPF	342,742	164,573	3,766	95,016	220,360	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	546	0	1,914	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	302,541	124,625	2,767	0	351,123	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	654,375	417,727	53,242	17,737	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	700,912	510,881	23,564	80,248	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	100,366	0	10,219	5,166	0	55.01
57.00	05700	CT SCAN	149,005	0	45,590	7,921	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	193,397	43,828	18,282	7,577	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	99,585	36,943	4,167	0	0	59.00
60.00	06000	LABORATORY	1,249,043	238,254	62,727	33,924	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	15,213	0	997	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	3,297	0	0	64.00
66.00	06600	PHYSICAL THERAPY	443,076	230,598	9,542	12,227	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	84,834	0	3,351	5,855	0	67.00
67.01	06701	AUDIOLOGY	37,130	0	1,307	4,305	0	67.01
68.00	06800	SPEECH PATHOLOGY	26,926	0	881	2,583	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	243,824	23,764	14,221	26,003	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	496,614	0	7,772	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	768,056	0	10,672	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	353,806	0	17,190	18,770	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	88,014	98,189	0	46,151	0	90.01
90.02	09002	CLINIC	0	0	0	67,849	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	177	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	92	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	7	0	108	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	1,080	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	30,718	0	814	0	0	90.13
90.14	09014	WOUND CARE	132,940	90,019	3,822	0	0	90.14
91.00	09100	EMERGENCY	771,643	631,112	38,112	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	436,930	45,215	7,856	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,042,345	3,684,811	370,042	957,965	1,129,674	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	4,115	16,031	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,289,598	974,748	0	0	0	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	9,339	36,378	0	0	0	194.01
194.02	07952	BOUTIQUE SERVICES	171,245	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	364,850	10,276	0	0	0	194.03
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)	17,881,492	4,722,244	370,042	957,965	1,129,674	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/26/2017 10:44 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	988,458					11.00
13.00	01300	NURSING ADMINISTRATION	19,125	825,674				13.00
15.00	01500	PHARMACY	38,250	0	1,539,110			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	77,506	0	0	2,120,487		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	260,703	174,750	798	521,093	7,964,220	30.00
31.00	03100	INTENSIVE CARE UNIT	21,138	51,450	188	108,346	2,637,728	31.00
40.00	04000	SUBPROVIDER - IPF	33,217	80,083	23	128,983	2,775,355	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	7,761	0	12,941	43.00
44.00	04400	SKILLED NURSING FACILITY	0	66,119	9,640	0	2,363,237	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,151	125,045	15,265	187,026	4,751,855	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,184	0	3,888	500,456	5,338,138	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	3,020	0	1,404	54,173	674,096	55.01
57.00	05700	CT SCAN	4,026	0	351	61,912	1,010,734	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,066	0	0	33,536	1,269,653	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	7,958	0	0	644,511	59.00
60.00	06000	LABORATORY	82,539	0	71	51,593	7,937,433	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	91,957	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	3,297	64.00
66.00	06600	PHYSICAL THERAPY	41,270	62,716	3,228	100,607	3,109,444	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,112	29,703	0	43,854	607,120	67.00
67.01	06701	AUDIOLOGY	18,118	0	0	0	245,740	67.01
68.00	06800	SPEECH PATHOLOGY	19,125	5,010	0	0	188,598	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	41,270	55,965	200	96,738	1,716,042	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,138	0	0	0	2,998,281	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	4,603,060	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,151,451	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	34,224	9,954	69	216,692	931,535	90.01
90.02	09002	CLINIC	0	0	0	0	67,849	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	10	0	10	90.05
90.07	09007	UROLOGY CLINIC	0	0	2,099	0	2,276	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	8,292	0	0	8,840	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	23	0	172	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	6,459	90.12
90.13	09013	ALLERGY CLINIC	0	5,680	1,110	0	191,272	90.13
90.14	09014	WOUND CARE	0	15,720	4,360	0	908,801	90.14
91.00	09100	EMERGENCY	64,421	120,987	81,827	0	5,550,296	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	130,855	0	14,962	0	2,811,394	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	988,458	819,432	147,277	2,105,009	63,573,795	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	40,638	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,228	1,277,375	15,478	39,876,744	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0	0	92,216	194.01
194.02	07952	BOUTIQUE SERVICES	0	4,014	0	0	1,027,928	194.02
194.03	07953	RETAIL PHARMACY	0	0	114,458	0	2,306,258	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	988,458	825,674	1,539,110	2,120,487	106,917,579	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/26/2017 10:44 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW 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
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	7,964,220		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,637,728		31.00
40.00	04000	SUBPROVIDER - IPF	0	2,775,355		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	12,941		43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,363,237		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	4,751,855		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,338,138		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	674,096		55.01
57.00	05700	CT SCAN	0	1,010,734		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,269,653		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	644,511		59.00
60.00	06000	LABORATORY	0	7,937,433		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	91,957		63.00
64.00	06400	INTRAVENOUS THERAPY	0	3,297		64.00
66.00	06600	PHYSICAL THERAPY	0	3,109,444		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	607,120		67.00
67.01	06701	AUDIOLOGY	0	245,740		67.01
68.00	06800	SPEECH PATHOLOGY	0	188,598		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	0	1,716,042		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,998,281		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,603,060		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,151,451		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	931,535		90.01
90.02	09002	CLINIC	0	67,849		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0		90.03
90.04	09004	ENT CLINIC	0	0		90.04
90.05	09005	SURGERY CLINIC	0	10		90.05
90.07	09007	UROLOGY CLINIC	0	2,276		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	8,840		90.09
90.11	09011	NEUROLOGY CLINIC	0	172		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	6,459		90.12
90.13	09013	ALLERGY CLINIC	0	191,272		90.13
90.14	09014	WOUND CARE	0	908,801		90.14
91.00	09100	EMERGENCY	0	5,550,296		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	2,811,394		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	63,573,795		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	40,638		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	39,876,744		192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0		194.00
194.01	07951	CAFE/BOUTIQUE	0	92,216		194.01
194.02	07952	BOUTIQUE SERVICES	0	1,027,928		194.02
194.03	07953	RETAIL PHARMACY	0	2,306,258		194.03
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	106,917,579		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/26/2017 10:44 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,089	7,023	19,112	19,112	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	386,358	224,438	610,796	3,826	5.00
7.00	00700	OPERATION OF PLANT	0	506,170	294,038	800,208	205	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8	8.00
9.00	00900	HOUSEKEEPING	0	58,286	33,859	92,145	139	9.00
10.00	01000	DIETARY	0	130,468	75,790	206,258	148	10.00
11.00	01100	CAFETERIA	0	0	0	0	115	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	194	13.00
15.00	01500	PHARMACY	0	40,277	23,397	63,674	156	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	63,624	36,960	100,584	369	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	423,187	245,832	669,019	1,032	30.00
31.00	03100	INTENSIVE CARE UNIT	0	116,219	67,512	183,731	366	31.00
40.00	04000	SUBPROVIDER - IPF	0	133,065	77,298	210,363	406	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	100,765	58,535	159,300	310	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	337,752	196,202	533,954	697	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	413,071	239,956	653,027	416	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	120	55.01
57.00	05700	CT SCAN	0	0	0	0	59	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	35,437	20,586	56,023	100	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	29,870	17,352	47,222	48	59.00
60.00	06000	LABORATORY	0	192,639	111,905	304,544	736	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	186,449	108,310	294,759	524	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	121	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	68	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	39	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	19,214	11,162	30,376	314	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	79,390	46,118	125,508	64	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	1	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	37	90.13
90.14	09014	WOUND CARE	0	72,785	42,281	115,066	108	90.14
91.00	09100	EMERGENCY	0	510,283	296,427	806,710	829	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	98,874	57,437	156,311	543	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,946,272	2,292,418	6,238,690	12,098	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	12,962	7,530	20,492	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	891,987	518,162	1,410,149	6,906	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	29,413	17,086	46,499	0	194.01
194.02	07952	BOUTIQUE SERVICES	0	426,739	247,896	674,635	24	194.02
194.03	07953	RETAIL PHARMACY	0	8,309	4,827	13,136	84	194.03
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	5,315,682	3,087,919	8,403,601	19,112	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/26/2017 10:44 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	614,622					5.00
7.00	00700	OPERATION OF PLANT	27,146	827,559				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,127	0	2,135			8.00
9.00	00900	HOUSEKEEPING	5,092	12,633	0	110,009		9.00
10.00	01000	DIETARY	5,225	28,278	0	6,821	246,730	10.00
11.00	01100	CAFETERIA	5,568	0	0	2,274	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,585	0	0	1,028	0	13.00
15.00	01500	PHARMACY	8,237	8,730	0	2,076	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,064	13,790	0	4,548	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,008	91,723	107	34,553	92,044	30.00
31.00	03100	INTENSIVE CARE UNIT	12,024	25,190	26	9,176	29,870	31.00
40.00	04000	SUBPROVIDER - IPF	11,781	28,841	21	10,911	48,128	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	19	0	11	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	10,399	21,840	15	0	76,688	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,492	73,205	298	2,037	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,092	89,530	132	9,215	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	3,450	0	57	593	0	55.01
57.00	05700	CT SCAN	5,122	0	255	910	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,647	7,681	102	870	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,423	6,474	23	0	0	59.00
60.00	06000	LABORATORY	42,932	41,753	416	3,896	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	523	0	6	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	18	0	0	64.00
66.00	06600	PHYSICAL THERAPY	15,229	40,412	53	1,404	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,916	0	19	672	0	67.00
67.01	06701	AUDIOLOGY	1,276	0	7	494	0	67.01
68.00	06800	SPEECH PATHOLOGY	926	0	5	297	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	8,381	4,165	80	2,986	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,069	0	43	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	26,399	0	60	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,161	0	96	2,156	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	3,025	17,207	0	5,300	0	90.01
90.02	09002	CLINIC	0	0	0	7,792	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	1	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	3	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	1	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	37	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	1,056	0	5	0	0	90.13
90.14	09014	WOUND CARE	4,569	15,776	21	0	0	90.14
91.00	09100	EMERGENCY	26,523	110,601	213	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	15,018	7,924	44	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	379,544	645,753	2,135	110,009	246,730	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	141	2,809	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	216,189	170,821	0	0	0	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	321	6,375	0	0	0	194.01
194.02	07952	BOUTIQUE SERVICES	5,886	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	12,541	1,801	0	0	0	194.03
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)	614,622	827,559	2,135	110,009	246,730	202.00

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		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	7,957					11.00
13.00	01300	NURSING ADMINISTRATION	154	5,961				13.00
15.00	01500	PHARMACY	308	0	83,181			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	624	0	0	130,979		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,101	1,264	43	32,189	957,083	30.00
31.00	03100	INTENSIVE CARE UNIT	170	371	10	6,692	267,626	31.00
40.00	04000	SUBPROVIDER - IPF	267	578	1	7,967	319,264	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	419	0	449	43.00
44.00	04400	SKILLED NURSING FACILITY	0	477	521	0	269,550	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	186	903	825	11,552	646,149	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	227	0	210	30,912	807,761	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	24	0	76	3,346	7,666	55.01
57.00	05700	CT SCAN	32	0	19	3,824	10,221	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	81	0	0	2,071	73,575	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	57	0	0	57,247	59.00
60.00	06000	LABORATORY	664	0	4	3,187	398,132	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	529	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	18	64.00
66.00	06600	PHYSICAL THERAPY	332	453	174	6,214	359,554	66.00
67.00	06700	OCCUPATIONAL THERAPY	138	214	0	2,709	6,789	67.00
67.01	06701	AUDIOLOGY	146	0	0	0	1,991	67.01
68.00	06800	SPEECH PATHOLOGY	154	36	0	0	1,457	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	332	404	11	5,975	53,024	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	170	0	0	0	17,282	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	26,459	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	14,413	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	275	72	4	13,385	164,840	90.01
90.02	09002	CLINIC	0	0	0	0	7,792	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	1	0	1	90.05
90.07	09007	UROLOGY CLINIC	0	0	113	0	114	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	60	0	0	64	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	1	0	2	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	37	90.12
90.13	09013	ALLERGY CLINIC	0	41	60	0	1,199	90.13
90.14	09014	WOUND CARE	0	113	236	0	135,889	90.14
91.00	09100	EMERGENCY	519	873	4,422	0	950,690	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,053	0	809	0	181,702	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,957	5,916	7,959	130,023	5,738,569	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	23,442	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	16	69,036	956	1,874,073	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0	0	53,195	194.01
194.02	07952	BOUTIQUE SERVICES	0	29	0	0	680,574	194.02
194.03	07953	RETAIL PHARMACY	0	0	6,186	0	33,748	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	7,957	5,961	83,181	130,979	8,403,601	202.00

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		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW 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
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	957,083		30.00
31.00	03100	INTENSIVE CARE UNIT	0	267,626		31.00
40.00	04000	SUBPROVIDER - IPF	0	319,264		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	449		43.00
44.00	04400	SKILLED NURSING FACILITY	0	269,550		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	646,149		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	807,761		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	7,666		55.01
57.00	05700	CT SCAN	0	10,221		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	73,575		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	57,247		59.00
60.00	06000	LABORATORY	0	398,132		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	529		63.00
64.00	06400	INTRAVENOUS THERAPY	0	18		64.00
66.00	06600	PHYSICAL THERAPY	0	359,554		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,789		67.00
67.01	06701	AUDIOLOGY	0	1,991		67.01
68.00	06800	SPEECH PATHOLOGY	0	1,457		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	0	53,024		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,282		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	26,459		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,413		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	164,840		90.01
90.02	09002	CLINIC	0	7,792		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0		90.03
90.04	09004	ENT CLINIC	0	0		90.04
90.05	09005	SURGERY CLINIC	0	1		90.05
90.07	09007	UROLOGY CLINIC	0	114		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	64		90.09
90.11	09011	NEUROLOGY CLINIC	0	2		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	37		90.12
90.13	09013	ALLERGY CLINIC	0	1,199		90.13
90.14	09014	WOUND CARE	0	135,889		90.14
91.00	09100	EMERGENCY	0	950,690		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	181,702		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	5,738,569		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	23,442		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,874,073		192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0		194.00
194.01	07951	CAFE/BOUTIQUE	0	53,195		194.01
194.02	07952	BOUTIQUE SERVICES	0	680,574		194.02
194.03	07953	RETAIL PHARMACY	0	33,748		194.03
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	8,403,601		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/26/2017 10:44 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW 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	NEW CAP REL COSTS-BLDG & FIXT	255,907					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		255,907				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	582	582	53,594,731			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,600	18,600	10,716,736	-17,881,492	89,036,087	5.00
7.00	00700	OPERATION OF PLANT	24,368	24,368	572,967	0	3,932,470	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	22,970	0	308,154	8.00
9.00	00900	HOUSEKEEPING	2,806	2,806	388,842	0	737,719	9.00
10.00	01000	DIETARY	6,281	6,281	415,874	0	756,903	10.00
11.00	01100	CAFETERIA	0	0	321,457	0	806,651	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	542,855	0	664,200	13.00
15.00	01500	PHARMACY	1,939	1,939	435,867	0	1,193,307	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,063	3,063	1,032,616	0	1,602,789	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,373	20,373	2,889,440	0	4,781,746	30.00
31.00	03100	INTENSIVE CARE UNIT	5,595	5,595	1,024,187	0	1,741,794	31.00
40.00	04000	SUBPROVIDER - IPF	6,406	6,406	1,138,593	0	1,706,592	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	2,720	43.00
44.00	04400	SKILLED NURSING FACILITY	4,851	4,851	867,050	0	1,506,422	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,260	16,260	1,952,859	0	3,258,287	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,886	19,886	1,165,742	0	3,490,005	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	336,558	0	499,748	55.01
57.00	05700	CT SCAN	0	0	164,644	0	741,929	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,706	1,706	280,913	0	962,967	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,438	1,438	135,130	0	495,858	59.00
60.00	06000	LABORATORY	9,274	9,274	2,060,903	0	6,219,282	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	75,747	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	8,976	8,976	1,467,663	0	2,206,180	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	339,428	0	422,411	67.00
67.01	06701	AUDIOLOGY	0	0	190,232	0	184,880	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	110,095	0	134,073	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	925	925	880,162	0	1,214,057	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,472,757	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	3,824,332	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,761,685	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	3,822	3,822	178,259	0	438,242	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	3,193	0	456	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	34	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	5,379	90.12
90.13	09013	ALLERGY CLINIC	0	0	102,614	0	152,950	90.13
90.14	09014	WOUND CARE	3,504	3,504	301,904	0	661,940	90.14
91.00	09100	EMERGENCY	24,566	24,566	2,322,753	0	3,842,194	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,760	4,760	1,520,507	0	2,175,576	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	189,981	189,981	33,883,013	-17,881,492	54,982,436	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	624	0	0	20,492	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	42,942	42,942	19,408,093	0	31,317,317	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	1,416	1,416	0	0	46,499	194.01
194.02	07952	BOUTIQUE SERVICES	20,544	20,544	67,530	0	852,669	194.02
194.03	07953	RETAIL PHARMACY	400	400	236,095	0	1,816,674	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/26/2017 10:44 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	5,315,682	3,087,919	7,648,321		17,881,492	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.771929	12.066567	0.142707		0.200834	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			19,112		614,622	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000357		0.006903	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/26/2017 10:44 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (GROSS CHARGES)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	183,813					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	295,532,009				8.00
9.00	00900	HOUSEKEEPING	2,806	0	139,073			9.00
10.00	01000	DIETARY	6,281	0	8,623	44,621		10.00
11.00	01100	CAFETERIA	0	0	2,875	0	982	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,300	0	19	13.00
15.00	01500	PHARMACY	1,939	0	2,625	0	38	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,063	0	5,750	0	77	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,373	15,245,904	43,681	16,646	259	30.00
31.00	03100	INTENSIVE CARE UNIT	5,595	3,671,401	11,600	5,402	21	31.00
40.00	04000	SUBPROVIDER - IPF	6,406	3,008,160	13,794	8,704	33	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	1,528,801	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,851	2,210,215	0	13,869	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,260	42,525,174	2,575	0	23	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,886	18,821,312	11,650	0	28	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	8,162,342	750	0	3	55.01
57.00	05700	CT SCAN	0	36,413,892	1,150	0	4	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,706	14,602,598	1,100	0	10	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,438	3,328,626	0	0	0	59.00
60.00	06000	LABORATORY	9,274	50,070,265	4,925	0	82	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	796,586	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	2,633,685	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	8,976	7,621,615	1,775	0	41	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,676,279	850	0	17	67.00
67.01	06701	AUDIOLOGY	0	1,044,246	625	0	18	67.01
68.00	06800	SPEECH PATHOLOGY	0	703,482	375	0	19	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	925	11,358,937	3,775	0	41	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,208,014	0	0	21	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	8,523,813	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,730,248	2,725	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	3,822	0	6,700	0	34	90.01
90.02	09002	CLINIC	0	0	9,850	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	141,010	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	86,589	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	650,461	0	0	0	90.13
90.14	09014	WOUND CARE	3,504	3,052,674	0	0	0	90.14
91.00	09100	EMERGENCY	24,566	30,440,785	0	0	64	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,760	6,274,895	0	0	130	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	143,431	295,532,009	139,073	44,621	982	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	37,942	0	0	0	0	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	1,416	0	0	0	0	194.01
194.02	07952	BOUTIQUE SERVICES	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	400	0	0	0	0	194.03
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)	4,722,244	370,042	957,965	1,129,674	988,458	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.690479	0.001252	6.888217	25.317093	1,006.576375	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/26/2017 10:44 am

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (GROSS CHARGES)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	827,559	2,135	110,009	246,730	7,957	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	4.502179	0.000007	0.791016	5.529459	8.102851	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/26/2017 10:44 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW 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	390,613				13.00
15.00	01500	PHARMACY	0	2,259,682			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	41,100		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	82,671	1,172	10,100		30.00
31.00	03100	INTENSIVE CARE UNIT	24,340	276	2,100		31.00
40.00	04000	SUBPROVIDER - IPF	37,886	34	2,500		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
43.00	04300	NURSERY	0	11,395	0		43.00
44.00	04400	SKILLED NURSING FACILITY	31,280	14,153	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	59,157	22,411	3,625		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,708	9,700		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
55.01	05501	ULTRA SOUND	0	2,061	1,050		55.01
57.00	05700	CT SCAN	0	516	1,200		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	650		58.00
59.00	05900	CARDIAC CATHETERIZATION	3,765	0	0		59.00
60.00	06000	LABORATORY	0	104	1,000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	29,670	4,740	1,950		66.00
67.00	06700	OCCUPATIONAL THERAPY	14,052	0	850		67.00
67.01	06701	AUDIOLOGY	0	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	2,370	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIOLOGY	26,476	294	1,875		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	4,709	102	4,200		90.01
90.02	09002	CLINIC	0	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0		90.03
90.04	09004	ENT CLINIC	0	0	0		90.04
90.05	09005	SURGERY CLINIC	0	14	0		90.05
90.07	09007	UROLOGY CLINIC	0	3,082	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	3,923	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	34	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0		90.12
90.13	09013	ALLERGY CLINIC	2,687	1,629	0		90.13
90.14	09014	WOUND CARE	7,437	6,401	0		90.14
91.00	09100	EMERGENCY	57,237	120,136	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	21,967	0		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	387,660	216,229	40,800		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,054	1,875,409	300		192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0		194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0		194.01
194.02	07952	BOUTIQUE SERVICES	1,899	0	0		194.02
194.03	07953	RETAIL PHARMACY	0	168,044	0		194.03
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)	825,674	1,539,110	2,120,487		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/26/2017 10:44 am

	Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
		13.00	15.00	16.00		
203.00	Unit cost multiplier (Wkst. B, Part I)	2.113790	0.681118	51.593358		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	5,961	83,181	130,979		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.015261	0.036811	3.186837		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/26/2017 10:44 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,964,220		7,964,220	0	7,964,220	30.00
31.00	03100	INTENSIVE CARE UNIT	2,637,728		2,637,728	0	2,637,728	31.00
40.00	04000	SUBPROVIDER - IPF	2,775,355		2,775,355	34,318	2,809,673	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	12,941		12,941	0	12,941	43.00
44.00	04400	SKILLED NURSING FACILITY	2,363,237		2,363,237	0	2,363,237	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,751,855		4,751,855	0	4,751,855	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,338,138		5,338,138	0	5,338,138	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
55.01	05501	ULTRA SOUND	674,096		674,096	0	674,096	55.01
57.00	05700	CT SCAN	1,010,734		1,010,734	0	1,010,734	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,269,653		1,269,653	0	1,269,653	58.00
59.00	05900	CARDIAC CATHETERIZATION	644,511		644,511	0	644,511	59.00
60.00	06000	LABORATORY	7,937,433		7,937,433	0	7,937,433	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	91,957		91,957	0	91,957	63.00
64.00	06400	INTRAVENOUS THERAPY	3,297		3,297	0	3,297	64.00
66.00	06600	PHYSICAL THERAPY	3,109,444	0	3,109,444	0	3,109,444	66.00
67.00	06700	OCCUPATIONAL THERAPY	607,120	0	607,120	0	607,120	67.00
67.01	06701	AUDIOLOGY	245,740	0	245,740	0	245,740	67.01
68.00	06800	SPEECH PATHOLOGY	188,598	0	188,598	0	188,598	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	06901	CARDIOLOGY	1,716,042		1,716,042	0	1,716,042	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,998,281		2,998,281	0	2,998,281	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,603,060		4,603,060	0	4,603,060	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,151,451		2,151,451	0	2,151,451	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	931,535		931,535	0	931,535	90.01
90.02	09002	CLINIC	67,849		67,849	0	67,849	90.02
90.03	09003	DERMATOLOGY CLINIC	0		0	0	0	90.03
90.04	09004	ENT CLINIC	0		0	0	0	90.04
90.05	09005	SURGERY CLINIC	10		10	0	10	90.05
90.07	09007	UROLOGY CLINIC	2,276		2,276	0	2,276	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	8,840		8,840	0	8,840	90.09
90.11	09011	NEUROLOGY CLINIC	172		172	0	172	90.11
90.12	09012	OPTHAMOLOGY CLINIC	6,459		6,459	0	6,459	90.12
90.13	09013	ALLERGY CLINIC	191,272		191,272	0	191,272	90.13
90.14	09014	WOUND CARE	908,801		908,801	0	908,801	90.14
91.00	09100	EMERGENCY	5,550,296		5,550,296	0	5,550,296	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,468,638		1,468,638		1,468,638	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,811,394		2,811,394	0	2,811,394	95.00
200.00		Subtotal (see instructions)	65,042,433	0	65,042,433	34,318	65,076,751	200.00
201.00		Less Observation Beds	1,468,638		1,468,638		1,468,638	201.00
202.00		Total (see instructions)	63,573,795	0	63,573,795	34,318	63,608,113	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/26/2017 10:44 am

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		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	12,638,150		12,638,150			30.00
31.00	03100	INTENSIVE CARE UNIT	3,671,401		3,671,401			31.00
40.00	04000	SUBPROVIDER - IPF	3,008,160		3,008,160			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	1,528,801		1,528,801			43.00
44.00	04400	SKILLED NURSING FACILITY	2,210,215		2,210,215			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,791,694	34,733,480	42,525,174	0.111742	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,330,051	17,491,261	18,821,312	0.283622	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
55.01	05501	ULTRA SOUND	482,643	7,679,699	8,162,342	0.082586	0.000000	55.01
57.00	05700	CT SCAN	4,114,196	32,299,696	36,413,892	0.027757	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	546,973	14,055,625	14,602,598	0.086947	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,138,960	2,189,666	3,328,626	0.193627	0.000000	59.00
60.00	06000	LABORATORY	8,597,820	41,472,445	50,070,265	0.158526	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	395,908	400,678	796,586	0.115439	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	1,200,838	1,432,847	2,633,685	0.001252	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	2,179,538	5,442,077	7,621,615	0.407977	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,043,203	633,076	2,676,279	0.226852	0.000000	67.00
67.01	06701	AUDIOLOGY	0	1,044,246	1,044,246	0.235328	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	130,718	572,764	703,482	0.268092	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	06901	CARDIOLOGY	4,650,191	6,708,746	11,358,937	0.151074	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,754,347	3,453,667	6,208,014	0.482969	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,376,893	5,146,920	8,523,813	0.540024	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,699,242	7,031,006	13,730,248	0.156694	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0.000000	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0.000000	0.000000	90.05
90.07	09007	UROLOGY CLINIC	1,307	139,703	141,010	0.016141	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0.000000	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	86,589	86,589	0.001986	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0.000000	0.000000	90.12
90.13	09013	ALLERGY CLINIC	59	650,402	650,461	0.294056	0.000000	90.13
90.14	09014	WOUND CARE	29,266	3,023,408	3,052,674	0.297707	0.000000	90.14
91.00	09100	EMERGENCY	3,513,518	26,927,267	30,440,785	0.182331	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,607,754	2,607,754	0.563181	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	13,858	6,261,037	6,274,895	0.448038	0.000000	95.00
200.00		Subtotal (see instructions)	74,047,950	221,484,059	295,532,009			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	74,047,950	221,484,059	295,532,009			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/26/2017 10:44 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.111742		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.283622		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
55.01	05501	ULTRA SOUND	0.082586		55.01
57.00	05700	CT SCAN	0.027757		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.086947		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.193627		59.00
60.00	06000	LABORATORY	0.158526		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.115439		63.00
64.00	06400	INTRAVENOUS THERAPY	0.001252		64.00
66.00	06600	PHYSICAL THERAPY	0.407977		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.226852		67.00
67.01	06701	AUDIOLOGY	0.235328		67.01
68.00	06800	SPEECH PATHOLOGY	0.268092		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIOLOGY	0.151074		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.482969		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.540024		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.156694		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		90.01
90.02	09002	CLINIC	0.000000		90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000		90.03
90.04	09004	ENT CLINIC	0.000000		90.04
90.05	09005	SURGERY CLINIC	0.000000		90.05
90.07	09007	UROLOGY CLINIC	0.016141		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000		90.09
90.11	09011	NEUROLOGY CLINIC	0.001986		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000		90.12
90.13	09013	ALLERGY CLINIC	0.294056		90.13
90.14	09014	WOUND CARE	0.297707		90.14
91.00	09100	EMERGENCY	0.182331		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.563181		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.448038		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/26/2017 10:44 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,964,220		7,964,220	0	7,964,220	30.00
31.00	03100	INTENSIVE CARE UNIT	2,637,728		2,637,728	0	2,637,728	31.00
40.00	04000	SUBPROVIDER - IPF	2,775,355		2,775,355	34,318	2,809,673	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	12,941		12,941	0	12,941	43.00
44.00	04400	SKILLED NURSING FACILITY	2,363,237		2,363,237	0	2,363,237	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,751,855		4,751,855	0	4,751,855	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,338,138		5,338,138	0	5,338,138	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
55.01	05501	ULTRA SOUND	674,096		674,096	0	674,096	55.01
57.00	05700	CT SCAN	1,010,734		1,010,734	0	1,010,734	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,269,653		1,269,653	0	1,269,653	58.00
59.00	05900	CARDIAC CATHETERIZATION	644,511		644,511	0	644,511	59.00
60.00	06000	LABORATORY	7,937,433		7,937,433	0	7,937,433	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	91,957		91,957	0	91,957	63.00
64.00	06400	INTRAVENOUS THERAPY	3,297		3,297	0	3,297	64.00
66.00	06600	PHYSICAL THERAPY	3,109,444	0	3,109,444	0	3,109,444	66.00
67.00	06700	OCCUPATIONAL THERAPY	607,120	0	607,120	0	607,120	67.00
67.01	06701	AUDIOLOGY	245,740	0	245,740	0	245,740	67.01
68.00	06800	SPEECH PATHOLOGY	188,598	0	188,598	0	188,598	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	06901	CARDIOLOGY	1,716,042		1,716,042	0	1,716,042	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,998,281		2,998,281	0	2,998,281	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,603,060		4,603,060	0	4,603,060	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,151,451		2,151,451	0	2,151,451	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	931,535		931,535	0	931,535	90.01
90.02	09002	CLINIC	67,849		67,849	0	67,849	90.02
90.03	09003	DERMATOLOGY CLINIC	0		0	0	0	90.03
90.04	09004	ENT CLINIC	0		0	0	0	90.04
90.05	09005	SURGERY CLINIC	10		10	0	10	90.05
90.07	09007	UROLOGY CLINIC	2,276		2,276	0	2,276	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	8,840		8,840	0	8,840	90.09
90.11	09011	NEUROLOGY CLINIC	172		172	0	172	90.11
90.12	09012	OPTHAMOLOGY CLINIC	6,459		6,459	0	6,459	90.12
90.13	09013	ALLERGY CLINIC	191,272		191,272	0	191,272	90.13
90.14	09014	WOUND CARE	908,801		908,801	0	908,801	90.14
91.00	09100	EMERGENCY	5,550,296		5,550,296	0	5,550,296	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,468,638		1,468,638		1,468,638	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,811,394		2,811,394	0	2,811,394	95.00
200.00		Subtotal (see instructions)	65,042,433	0	65,042,433	34,318	65,076,751	200.00
201.00		Less Observation Beds	1,468,638		1,468,638		1,468,638	201.00
202.00		Total (see instructions)	63,573,795	0	63,573,795	34,318	63,608,113	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/26/2017 10:44 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,638,150		12,638,150			30.00
31.00	03100	INTENSIVE CARE UNIT	3,671,401		3,671,401			31.00
40.00	04000	SUBPROVIDER - IPF	3,008,160		3,008,160			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	1,528,801		1,528,801			43.00
44.00	04400	SKILLED NURSING FACILITY	2,210,215		2,210,215			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,791,694	34,733,480	42,525,174	0.111742	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,330,051	17,491,261	18,821,312	0.283622	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
55.01	05501	ULTRA SOUND	482,643	7,679,699	8,162,342	0.082586	0.000000	55.01
57.00	05700	CT SCAN	4,114,196	32,299,696	36,413,892	0.027757	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	546,973	14,055,625	14,602,598	0.086947	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,138,960	2,189,666	3,328,626	0.193627	0.000000	59.00
60.00	06000	LABORATORY	8,597,820	41,472,445	50,070,265	0.158526	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	395,908	400,678	796,586	0.115439	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	1,200,838	1,432,847	2,633,685	0.001252	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	2,179,538	5,442,077	7,621,615	0.407977	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,043,203	633,076	2,676,279	0.226852	0.000000	67.00
67.01	06701	AUDIOLOGY	0	1,044,246	1,044,246	0.235328	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	130,718	572,764	703,482	0.268092	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	06901	CARDIOLOGY	4,650,191	6,708,746	11,358,937	0.151074	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,754,347	3,453,667	6,208,014	0.482969	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,376,893	5,146,920	8,523,813	0.540024	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,699,242	7,031,006	13,730,248	0.156694	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0.000000	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0.000000	0.000000	90.05
90.07	09007	UROLOGY CLINIC	1,307	139,703	141,010	0.016141	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0.000000	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	86,589	86,589	0.001986	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0.000000	0.000000	90.12
90.13	09013	ALLERGY CLINIC	59	650,402	650,461	0.294056	0.000000	90.13
90.14	09014	WOUND CARE	29,266	3,023,408	3,052,674	0.297707	0.000000	90.14
91.00	09100	EMERGENCY	3,513,518	26,927,267	30,440,785	0.182331	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,607,754	2,607,754	0.563181	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	13,858	6,261,037	6,274,895	0.448038	0.000000	95.00
200.00		Subtotal (see instructions)	74,047,950	221,484,059	295,532,009			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	74,047,950	221,484,059	295,532,009			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/26/2017 10:44 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
55.01	05501	ULTRA SOUND	0.000000		55.01
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
67.01	06701	AUDIOLOGY	0.000000		67.01
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIOLOGY	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		90.01
90.02	09002	CLINIC	0.000000		90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000		90.03
90.04	09004	ENT CLINIC	0.000000		90.04
90.05	09005	SURGERY CLINIC	0.000000		90.05
90.07	09007	UROLOGY CLINIC	0.000000		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000		90.09
90.11	09011	NEUROLOGY CLINIC	0.000000		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000		90.12
90.13	09013	ALLERGY CLINIC	0.000000		90.13
90.14	09014	WOUND CARE	0.000000		90.14
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part I Date/Time Prepared: 5/26/2017 10:44 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	957,083	0	957,083	6,258	152.94	30.00
31.00	INTENSIVE CARE UNIT	267,626		267,626	1,683	159.02	31.00
40.00	SUBPROVIDER - IPF	319,264	0	319,264	2,755	115.89	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	449		449	993	0.45	43.00
44.00	SKILLED NURSING FACILITY	269,550		269,550	4,390	61.40	44.00
200.00	Total (lines 30-199)	1,813,972		1,813,972	16,079		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,274	347,786	30.00
31.00	INTENSIVE CARE UNIT	847	134,690	31.00
40.00	SUBPROVIDER - IPF	2,338	270,951	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	3,286	201,760	44.00
200.00	Total (lines 30-199)	8,745	955,187	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/26/2017 10:44 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	646,149	42,525,174	0.015195	4,266,166	64,824	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	807,761	18,821,312	0.042917	780,457	33,495	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	7,666	8,162,342	0.000939	244,077	229	55.01
57.00	05700	CT SCAN	10,221	36,413,892	0.000281	2,057,312	578	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	73,575	14,602,598	0.005038	316,286	1,593	58.00
59.00	05900	CARDIAC CATHETERIZATION	57,247	3,328,626	0.017198	419,102	7,208	59.00
60.00	06000	LABORATORY	398,132	50,070,265	0.007951	4,395,475	34,948	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	529	796,586	0.000664	135,097	90	63.00
64.00	06400	INTRAVENOUS THERAPY	18	2,633,685	0.000007	503,413	4	64.00
66.00	06600	PHYSICAL THERAPY	359,554	7,621,615	0.047176	309,455	14,599	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,789	2,676,279	0.002537	167,515	425	67.00
67.01	06701	AUDIOLOGY	1,991	1,044,246	0.001907	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	1,457	703,482	0.002071	47,859	99	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	53,024	11,358,937	0.004668	2,369,993	11,063	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,282	6,208,014	0.002784	1,182,852	3,293	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	26,459	8,523,813	0.003104	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,413	13,730,248	0.001050	2,922,645	3,069	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	164,840	0	0.000000	0	0	90.01
90.02	09002	CLINIC	7,792	0	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	1	0	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	114	141,010	0.000808	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	64	0	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	2	86,589	0.000023	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	37	0	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	1,199	650,461	0.001843	0	0	90.13
90.14	09014	WOUND CARE	135,889	3,052,674	0.044515	108	5	90.14
91.00	09100	EMERGENCY	950,690	30,440,785	0.031231	1,830,047	57,154	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	176,491	2,607,754	0.067679	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	3,919,386	266,200,387		21,947,859	232,676	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 5/26/2017 10:44 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
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0			0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,258	0.00	2,274	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,683	0.00	847	0		31.00
40.00	04000	SUBPROVIDER - IPF	2,755	0.00	2,338	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0		41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0		42.00
43.00	04300	NURSERY	993	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	4,390	0.00	3,286	0		44.00
200.00		Total (lines 30-199)	16,079		8,745	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/26/2017 10:44 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	0	55.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	0	90.13
90.14	09014	WOUND CARE	0	0	0	0	0	90.14
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/26/2017 10:44 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	42,525,174	0.000000	0.000000	4,266,166	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,821,312	0.000000	0.000000	780,457	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
55.01	05501	ULTRA SOUND	0	8,162,342	0.000000	0.000000	244,077	55.01
57.00	05700	CT SCAN	0	36,413,892	0.000000	0.000000	2,057,312	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	14,602,598	0.000000	0.000000	316,286	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,328,626	0.000000	0.000000	419,102	59.00
60.00	06000	LABORATORY	0	50,070,265	0.000000	0.000000	4,395,475	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	796,586	0.000000	0.000000	135,097	63.00
64.00	06400	INTRAVENOUS THERAPY	0	2,633,685	0.000000	0.000000	503,413	64.00
66.00	06600	PHYSICAL THERAPY	0	7,621,615	0.000000	0.000000	309,455	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,676,279	0.000000	0.000000	167,515	67.00
67.01	06701	AUDIOLOGY	0	1,044,246	0.000000	0.000000	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	703,482	0.000000	0.000000	47,859	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
69.01	06901	CARDIOLOGY	0	11,358,937	0.000000	0.000000	2,369,993	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,208,014	0.000000	0.000000	1,182,852	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	8,523,813	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,730,248	0.000000	0.000000	2,922,645	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	90.01
90.02	09002	CLINIC	0	0	0.000000	0.000000	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0.000000	0	90.03
90.04	09004	ENT CLINIC	0	0	0.000000	0.000000	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0.000000	0.000000	0	90.05
90.07	09007	UROLOGY CLINIC	0	141,010	0.000000	0.000000	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0.000000	0.000000	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	86,589	0.000000	0.000000	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0.000000	0.000000	0	90.12
90.13	09013	ALLERGY CLINIC	0	650,461	0.000000	0.000000	0	90.13
90.14	09014	WOUND CARE	0	3,052,674	0.000000	0.000000	108	90.14
91.00	09100	EMERGENCY	0	30,440,785	0.000000	0.000000	1,830,047	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,607,754	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	266,200,387			21,947,859	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/26/2017 10:44 am

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		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	10,608,077	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,261,846	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
55.01	05501	ULTRA SOUND	0	1,470,853	0		55.01
57.00	05700	CT SCAN	0	8,343,211	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,681,564	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	915,606	0		59.00
60.00	06000	LABORATORY	0	4,314,443	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	150,345	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	296,551	0		64.00
66.00	06600	PHYSICAL THERAPY	0	19,822	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,514	0		67.00
67.01	06701	AUDIOLOGY	0	138,837	0		67.01
68.00	06800	SPEECH PATHOLOGY	0	225	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIOLOGY	0	2,655,126	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	793,550	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	68,448	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,708,131	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		90.01
90.02	09002	CLINIC	0	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0		90.03
90.04	09004	ENT CLINIC	0	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	0	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0		90.12
90.13	09013	ALLERGY CLINIC	0	0	0		90.13
90.14	09014	WOUND CARE	0	324,162	0		90.14
91.00	09100	EMERGENCY	0	5,310,530	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,091,695	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	47,160,536	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/26/2017 10:44 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	0.111742	10,608,077	6,671	8	1,185,368	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.283622	4,261,846	74	0	1,208,753	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.082586	1,470,853	0	0	121,472	55.01
57.00	05700	CT SCAN	0.027757	8,343,211	0	5,830	231,583	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.086947	4,681,564	4	0	407,048	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.193627	915,606	990	331	177,286	59.00
60.00	06000	LABORATORY	0.158526	4,314,443	272	0	683,951	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.115439	150,345	0	0	17,356	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001252	296,551	0	0	371	64.00
66.00	06600	PHYSICAL THERAPY	0.407977	19,822	0	0	8,087	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.226852	7,514	0	0	1,705	67.00
67.01	06701	AUDIOLOGY	0.235328	138,837	0	0	32,672	67.01
68.00	06800	SPEECH PATHOLOGY	0.268092	225	0	0	60	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.151074	2,655,126	899	0	401,121	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.482969	793,550	5,227	0	383,260	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.540024	68,448	0	0	36,964	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.156694	1,708,131	0	19,908	267,654	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.016141	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.001986	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.294056	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.297707	324,162	311	1,359	96,505	90.14
91.00	09100	EMERGENCY	0.182331	5,310,530	86	0	968,274	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.563181	1,091,695	0	0	614,822	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.448038		0			95.00
200.00		Subtotal (see instructions)		47,160,536	14,534	27,436	6,844,312	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		47,160,536	14,534	27,436	6,844,312	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/26/2017 10:44 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	745	1		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	0		55.01
57.00	05700	CT SCAN	0	162		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	192	64		59.00
60.00	06000	LABORATORY	43	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
67.01	06701	AUDIOLOGY	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	136	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,524	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,119		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0		90.01
90.02	09002	CLINIC	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0		90.03
90.04	09004	ENT CLINIC	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0		90.12
90.13	09013	ALLERGY CLINIC	0	0		90.13
90.14	09014	WOUND CARE	93	405		90.14
91.00	09100	EMERGENCY	16	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	3,770	3,751		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,770	3,751		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/26/2017 10:44 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	646,149	42,525,174	0.015195	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	807,761	18,821,312	0.042917	30,137	1,293	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	7,666	8,162,342	0.000939	4,455	4	55.01
57.00	05700	CT SCAN	10,221	36,413,892	0.000281	48,335	14	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	73,575	14,602,598	0.005038	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	57,247	3,328,626	0.017198	0	0	59.00
60.00	06000	LABORATORY	398,132	50,070,265	0.007951	498,354	3,962	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	529	796,586	0.000664	1,572	1	63.00
64.00	06400	INTRAVENOUS THERAPY	18	2,633,685	0.000007	0	0	64.00
66.00	06600	PHYSICAL THERAPY	359,554	7,621,615	0.047176	25,372	1,197	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,789	2,676,279	0.002537	844	2	67.00
67.01	06701	AUDIOLOGY	1,991	1,044,246	0.001907	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	1,457	703,482	0.002071	4,844	10	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	53,024	11,358,937	0.004668	78,246	365	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,282	6,208,014	0.002784	69,726	194	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	26,459	8,523,813	0.003104	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,413	13,730,248	0.001050	614,964	646	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	164,840	0	0.000000	0	0	90.01
90.02	09002	CLINIC	7,792	0	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	1	0	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	114	141,010	0.000808	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	64	0	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	2	86,589	0.000023	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	37	0	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	1,199	650,461	0.001843	0	0	90.13
90.14	09014	WOUND CARE	135,889	3,052,674	0.044515	0	0	90.14
91.00	09100	EMERGENCY	950,690	30,440,785	0.031231	10,380	324	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,607,754	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	3,742,895	266,200,387		1,387,229	8,012	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/26/2017 10:44 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	0	55.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	0	90.13
90.14	09014	WOUND CARE	0	0	0	0	0	90.14
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/26/2017 10:44 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	42,525,174	0.000000	0.000000	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,821,312	0.000000	0.000000	30,137	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
55.01	05501	ULTRA SOUND	0	8,162,342	0.000000	0.000000	4,455	55.01
57.00	05700	CT SCAN	0	36,413,892	0.000000	0.000000	48,335	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	14,602,598	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,328,626	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	50,070,265	0.000000	0.000000	498,354	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	796,586	0.000000	0.000000	1,572	63.00
64.00	06400	INTRAVENOUS THERAPY	0	2,633,685	0.000000	0.000000	0	64.00
66.00	06600	PHYSICAL THERAPY	0	7,621,615	0.000000	0.000000	25,372	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,676,279	0.000000	0.000000	844	67.00
67.01	06701	AUDIOLOGY	0	1,044,246	0.000000	0.000000	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	703,482	0.000000	0.000000	4,844	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
69.01	06901	CARDIOLOGY	0	11,358,937	0.000000	0.000000	78,246	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,208,014	0.000000	0.000000	69,726	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	8,523,813	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,730,248	0.000000	0.000000	614,964	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	90.01
90.02	09002	CLINIC	0	0	0.000000	0.000000	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0.000000	0	90.03
90.04	09004	ENT CLINIC	0	0	0.000000	0.000000	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0.000000	0.000000	0	90.05
90.07	09007	UROLOGY CLINIC	0	141,010	0.000000	0.000000	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0.000000	0.000000	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	86,589	0.000000	0.000000	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0.000000	0.000000	0	90.12
90.13	09013	ALLERGY CLINIC	0	650,461	0.000000	0.000000	0	90.13
90.14	09014	WOUND CARE	0	3,052,674	0.000000	0.000000	0	90.14
91.00	09100	EMERGENCY	0	30,440,785	0.000000	0.000000	10,380	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,607,754	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	266,200,387			1,387,229	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/26/2017 10:44 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
55.01	05501	ULTRA SOUND	0	0	0		55.01
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
67.01	06701	AUDIOLOGY	0	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIOLOGY	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		90.01
90.02	09002	CLINIC	0	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0		90.03
90.04	09004	ENT CLINIC	0	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	0	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0		90.12
90.13	09013	ALLERGY CLINIC	0	0	0		90.13
90.14	09014	WOUND CARE	0	0	0		90.14
91.00	09100	EMERGENCY	0	2,160	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	2,160	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V | Date/Time Prepared: 5/26/2017 10:44 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.111742	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.283622	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.082586	0	0	0	0	55.01
57.00	05700	CT SCAN	0.027757	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.086947	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.193627	0	0	0	0	59.00
60.00	06000	LABORATORY	0.158526	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.115439	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001252	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.407977	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.226852	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0.235328	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.268092	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.151074	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.482969	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.540024	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.156694	0	0	4,791	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.016141	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.001986	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.294056	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.297707	0	0	0	0	90.14
91.00	09100	EMERGENCY	0.182331	2,160	0	0	394	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.563181	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.448038		0			95.00
200.00		Subtotal (see instructions)		2,160	0	4,791	394	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		2,160	0	4,791	394	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V | Date/Time Prepared: 5/26/2017 10:44 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	0		55.01
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
67.01	06701	AUDIOLOGY	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	751		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0		90.01
90.02	09002	CLINIC	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0		90.03
90.04	09004	ENT CLINIC	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0		90.12
90.13	09013	ALLERGY CLINIC	0	0		90.13
90.14	09014	WOUND CARE	0	0		90.14
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	751		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	751		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/26/2017 10:44 am

Title XVIII | Skilled Nursing Facility | 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	0	55.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	0	90.13
90.14	09014	WOUND CARE	0	0	0	0	0	90.14
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/26/2017 10:44 am

Title XVIII | Skilled Nursing Facility | 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	42,525,174	0.000000	0.000000	2,406	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,821,312	0.000000	0.000000	29,621	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
55.01	05501	ULTRA SOUND	0	8,162,342	0.000000	0.000000	17,282	55.01
57.00	05700	CT SCAN	0	36,413,892	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	14,602,598	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,328,626	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	50,070,265	0.000000	0.000000	250,425	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	796,586	0.000000	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	2,633,685	0.000000	0.000000	0	64.00
66.00	06600	PHYSICAL THERAPY	0	7,621,615	0.000000	0.000000	1,212,881	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,676,279	0.000000	0.000000	1,341,806	67.00
67.01	06701	AUDIOLOGY	0	1,044,246	0.000000	0.000000	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	703,482	0.000000	0.000000	38,298	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
69.01	06901	CARDIOLOGY	0	11,358,937	0.000000	0.000000	541,912	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,208,014	0.000000	0.000000	248,383	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	8,523,813	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,730,248	0.000000	0.000000	881,907	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	90.01
90.02	09002	CLINIC	0	0	0.000000	0.000000	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0.000000	0	90.03
90.04	09004	ENT CLINIC	0	0	0.000000	0.000000	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0.000000	0.000000	0	90.05
90.07	09007	UROLOGY CLINIC	0	141,010	0.000000	0.000000	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0.000000	0.000000	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	86,589	0.000000	0.000000	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0.000000	0.000000	0	90.12
90.13	09013	ALLERGY CLINIC	0	650,461	0.000000	0.000000	0	90.13
90.14	09014	WOUND CARE	0	3,052,674	0.000000	0.000000	0	90.14
91.00	09100	EMERGENCY	0	30,440,785	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,607,754	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	266,200,387			4,564,921	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/26/2017 10:44 am

Title XVIII | Skilled Nursing Facility | 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
55.01	05501	ULTRA SOUND	0	0	0		55.01
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
67.01	06701	AUDIOLOGY	0	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIOLOGY	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		90.01
90.02	09002	CLINIC	0	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0		90.03
90.04	09004	ENT CLINIC	0	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	0	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0		90.12
90.13	09013	ALLERGY CLINIC	0	0	0		90.13
90.14	09014	WOUND CARE	0	0	0		90.14
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V | Date/Time Prepared: 5/26/2017 10:44 am

Title XVIII | Skilled Nursing Facility | 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	0.111742	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.283622	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.082586	0	0	0	0	55.01
57.00	05700	CT SCAN	0.027757	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.086947	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.193627	0	0	0	0	59.00
60.00	06000	LABORATORY	0.158526	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.115439	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001252	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.407977	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.226852	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0.235328	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.268092	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.151074	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.482969	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.540024	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.156694	0	0	629	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.016141	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.001986	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.294056	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.297707	0	0	0	0	90.14
91.00	09100	EMERGENCY	0.182331	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.563181	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.448038		0			95.00
200.00		Subtotal (see instructions)		0	0	629	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	629	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V | Date/Time Prepared: 5/26/2017 10:44 am

Title XVIII | Skilled Nursing Facility | 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	0		55.01
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
67.01	06701	AUDIOLOGY	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	99		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0		90.01
90.02	09002	CLINIC	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0		90.03
90.04	09004	ENT CLINIC	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0		90.12
90.13	09013	ALLERGY CLINIC	0	0		90.13
90.14	09014	WOUND CARE	0	0		90.14
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	99		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	99		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/26/2017 10:44 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,258	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,258	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,104	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,274	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)	7,964,220	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)	7,964,220	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)	7,964,220	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)	1,272.65	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,894,006	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,894,006	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/26/2017 10:44 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,637,728	1,683	1,567.28	847	1,327,486	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)	3,495,073	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	7,716,565	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)	482,476	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	232,676	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	715,152	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,001,413	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,154	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,272.65	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,468,638	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/26/2017 10:44 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	957,083	7,964,220	0.120173	1,468,638	176,491	90.00
91.00	Nursing School cost	0	7,964,220	0.000000	1,468,638	0	91.00
92.00	Allied health cost	0	7,964,220	0.000000	1,468,638	0	92.00
93.00	All other Medical Education	0	7,964,220	0.000000	1,468,638	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104 Component CCN: 15-S104	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/26/2017 10:44 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,755	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,755	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,755	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,338	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,809,673	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,809,673	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,809,673	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)	1,019.85	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,384,409	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,384,409	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/26/2017 10:44 am

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	245,032	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,629,441	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)	270,951	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	8,012	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	278,963	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,350,478	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/26/2017 10:44 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	319,264	2,809,673	0.113630	0	0	90.00
91.00	Nursing School cost	0	2,809,673	0.000000	0	0	91.00
92.00	Allied health cost	0	2,809,673	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,809,673	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104 Component CCN: 15-5832	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/26/2017 10:44 am
	Title XVIII	Skilled Nursing Facility	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)	4,390	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,390	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,390	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)	3,286	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,363,237	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,363,237	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,363,237	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1

Component CCN: 15-5832 | Date/Time Prepared: 5/26/2017 10:44 am

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	2,363,237	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	538.32	71.00
72.00	Program routine service cost (line 9 x line 71)	1,768,920	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,768,920	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,768,920	83.00
84.00	Program inpatient ancillary services (see instructions)	1,199,302	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,968,222	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104 Component CCN: 15-5832	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/26/2017 10:44 am
	Title XVIII	Skilled Nursing Facility	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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/26/2017 10:44 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,258	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,258	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,104	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)	171	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)	993	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)	7,964,220	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)	7,964,220	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)	7,964,220	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)	1,272.65	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	217,623	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)	217,623	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/26/2017 10:44 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	12,941	993	13.03	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,637,728	1,683	1,567.28	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)	94,287	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	311,910	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,154	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,272.65	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,468,638	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/26/2017 10:44 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	957,083	7,964,220	0.120173	1,468,638	176,491	90.00
91.00	Nursing School cost	0	7,964,220	0.000000	1,468,638	0	91.00
92.00	Allied health cost	0	7,964,220	0.000000	1,468,638	0	92.00
93.00	All other Medical Education	0	7,964,220	0.000000	1,468,638	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/26/2017 10:44 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		1,997,669		30.00
31.00	03100	INTENSIVE CARE UNIT		1,817,408		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.111742	4,266,166	476,710	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.283622	780,457	221,355	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.082586	244,077	20,157	55.01
57.00	05700	CT SCAN	0.027757	2,057,312	57,105	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.086947	316,286	27,500	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.193627	419,102	81,149	59.00
60.00	06000	LABORATORY	0.158526	4,395,475	696,797	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.115439	135,097	15,595	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001252	503,413	630	64.00
66.00	06600	PHYSICAL THERAPY	0.407977	309,455	126,251	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.226852	167,515	38,001	67.00
67.01	06701	AUDIOLOGY	0.235328	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.268092	47,859	12,831	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.151074	2,369,993	358,044	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.482969	1,182,852	571,281	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.540024	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.156694	2,922,645	457,961	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.016141	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.001986	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.294056	0	0	90.13
90.14	09014	WOUND CARE	0.297707	108	32	90.14
91.00	09100	EMERGENCY	0.182331	1,830,047	333,674	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.563181	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		21,947,859	3,495,073	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)		21,947,859		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/26/2017 10:44 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		2,529,358		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.111742	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.283622	30,137	8,548	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.082586	4,455	368	55.01
57.00	05700	CT SCAN	0.027757	48,335	1,342	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.086947	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.193627	0	0	59.00
60.00	06000	LABORATORY	0.158526	498,354	79,002	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.115439	1,572	181	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001252	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.407977	25,372	10,351	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.226852	844	191	67.00
67.01	06701	AUDIOLOGY	0.235328	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.268092	4,844	1,299	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.151074	78,246	11,821	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.482969	69,726	33,675	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.540024	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.156694	614,964	96,361	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.016141	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.001986	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.294056	0	0	90.13
90.14	09014	WOUND CARE	0.297707	0	0	90.14
91.00	09100	EMERGENCY	0.182331	10,380	1,893	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.563181	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,387,229	245,032	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)		1,387,229		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/26/2017 10:44 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.111742	2,406	269	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.283622	29,621	8,401	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.082586	17,282	1,427	55.01
57.00	05700	CT SCAN	0.027757	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.086947	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.193627	0	0	59.00
60.00	06000	LABORATORY	0.158526	250,425	39,699	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.115439	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001252	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.407977	1,212,881	494,828	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.226852	1,341,806	304,391	67.00
67.01	06701	AUDIOLOGY	0.235328	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.268092	38,298	10,267	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.151074	541,912	81,869	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.482969	248,383	119,961	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.540024	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.156694	881,907	138,190	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.016141	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.001986	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.294056	0	0	90.13
90.14	09014	WOUND CARE	0.297707	0	0	90.14
91.00	09100	EMERGENCY	0.182331	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.563181	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		4,564,921	1,199,302	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)		4,564,921		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/26/2017 10:44 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		366,347		30.00
31.00	03100	INTENSIVE CARE UNIT		45,202		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		89,668		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.111742	132,979	14,859	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.283622	11,931	3,384	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.082586	6,847	565	55.01
57.00	05700	CT SCAN	0.027757	43,506	1,208	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.086947	5,024	437	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.193627	2,976	576	59.00
60.00	06000	LABORATORY	0.158526	121,854	19,317	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.115439	6,806	786	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001252	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.407977	4,045	1,650	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.226852	2,043	463	67.00
67.01	06701	AUDIOLOGY	0.235328	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.268092	330	88	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.151074	39,588	5,981	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.482969	51,758	24,998	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.540024	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.156694	85,323	13,370	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.016141	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.001986	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.294056	0	0	90.13
90.14	09014	WOUND CARE	0.297707	317	94	90.14
91.00	09100	EMERGENCY	0.182331	35,708	6,511	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.563181	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		551,035	94,287	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)		551,035		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/26/2017 10:44 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)	4,329,133	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,443,044	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)	36,656	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)	64.85	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.05	30.00
31.00	Percentage of Medicaid patient days (see instructions)	25.51	31.00
32.00	Sum of lines 30 and 31	28.56	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00
34.00	Disproportionate share adjustment (see instructions)	173,165	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/26/2017 10:44 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000055964	0.000056628	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	358,513	338,490	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	268,395	85,318	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	353,713		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)	6,335,711		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	6,335,711	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	464,362	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	1,588	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	6,801,661	59.00
60.00	Primary payer payments	6,968	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	6,794,693	61.00
62.00	Deductibles billed to program beneficiaries	873,096	62.00
63.00	Coinsurance billed to program beneficiaries	1,288	63.00
64.00	Allowable bad debts (see instructions)	101,771	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	66,151	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	78,265	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	5,986,460	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	RURAL DEMONSTRATION PROJECT	0	70.50
70.88	SCH or MDH volume decrease adjustment	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	20,249	70.93
70.94	HRR adjustment amount (see instructions)	-3,832	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Date/Time Prepared: 5/26/2017 10:44 am

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2016	488,558	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	137,906	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,629,341	71.00
71.01	Sequestration adjustment (see instructions)		132,587	71.01
72.00	Interim payments		6,453,740	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)		43,014	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/26/2017 10:44 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,329,133	0	4,329,133		4,329,133	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,443,044	0		1,443,044	1,443,044	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	36,656	0	27,491	9,165	36,656	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	173,165	0	129,874	43,291	173,165	11.00
11.01	Uncompensated care payments	36.00	353,713	0	268,395	85,318	353,713	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,335,711	0	4,754,893	1,580,818	6,335,711	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,335,711	0	4,754,893	1,580,818	6,335,711	15.00
16.00	Payment for inpatient program capital	50.00	464,362	0	348,272	116,090	464,362	16.00
17.00	Special add-on payments for new technologies	54.00	1,588	0	1,191	397	1,588	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/26/2017 10:44 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	5,104,356	1,697,305	6,801,661	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	464,120	0	348,090	116,030	464,120	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	242	0	182	60	242	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	464,362	0	348,272	116,090	464,362	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.095714	0.081250		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			488,558		488,558	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				137,906	137,906	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/26/2017 10:44 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,329,133	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,443,044		5,772,177	5,772,177	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	36,656	0	36,656	36,656	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	173,165	0	173,165	173,165	11.00
11.01	Uncompensated care payments	36.00	353,713	268,395	85,318	353,713	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,335,711	268,395	6,067,316	6,335,711	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,335,711	268,395	6,067,316	6,335,711	15.00
16.00	Payment for inpatient program capital	50.00	464,362	0	464,362	464,362	16.00
17.00	Special add-on payments for new technologies	54.00	1,588	0	1,588	1,588	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			268,395	6,533,266	6,801,661	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/26/2017 10:44 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	464,120	0	464,120	464,120	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	242	0	242	242	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	464,362	0	464,362	464,362	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	488,558	488,558		488,558	28.00
29.00	Low volume adjustment on or after October 1	70.97	137,906		137,906	137,906	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	20,249	0	20,249	20,249	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-3,832	0	-3,832	-3,832	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/26/2017 10:44 am
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,521	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	6,844,312	2.00
3.00	PPS payments	7,339,744	3.00
4.00	Outlier payment (see instructions)	1,325	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)	7,521	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	41,970	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)	41,970	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)	41,970	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	34,449	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)	7,521	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)	7,341,069	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,495,317	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)	5,853,273	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)	5,853,273	30.00
31.00	Primary payer payments	1,283	31.00
32.00	Subtotal (line 30 minus line 31)	5,851,990	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)	127,464	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	82,852	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	115,762	36.00
37.00	Subtotal (see instructions)	5,934,842	37.00
38.00	MSP-LCC reconciliation amount from PS&R	248	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	5,934,594	40.00
40.01	Sequestration adjustment (see instructions)	118,692	40.01
41.00	Interim payments	5,733,614	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	82,288	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

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	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	751	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	394	2.00
3.00	PPS payments	552	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	751	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	4,791	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)	4,791	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)	4,791	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	4,040	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)	751	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)	552	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,303	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,303	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,303	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	1,303	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,303	40.00
40.01	Sequestration adjustment (see instructions)	26	40.01
41.00	Interim payments	1,480	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-203	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104 Component CCN: 15-5832	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/26/2017 10:44 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	99	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		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)	99	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	629	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)	629	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)	629	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	530	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)	99	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)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		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)	99	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)	99	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	99	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	99	37.00
38.00	MSP-LCC reconciliation amount from PS&R		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)	99	40.00
40.01	Sequestration adjustment (see instructions)	2	40.01
41.00	Interim payments	123	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-26	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)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I Date/Time Prepared: 5/26/2017 10:44 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		6,453,740		5,733,614	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		6,453,740		5,733,614	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		43,014		82,288	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,496,754		5,815,902	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: 15-0104 | Component CCN: 15-S104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2017 10:44 am

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,029,759		1,480	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,029,759		1,480	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		2		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		203	6.02
7.00	Total Medicare program liability (see instructions)		2,029,761		1,277	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: 15-0104 | Component CCN: 15-5832 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2017 10:44 am

Title XVIII | Skilled Nursing Facility | 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		1,389,276		123	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)		1,389,276		123	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		26	6.02
7.00	Total Medicare program liability (see instructions)		1,389,276		97	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: 15-0104	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/26/2017 10:44 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	2,289	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	3,121	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	482	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	6,787	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	295,532,009	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	2,278,925	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	Provider CCN: 15-0104 Component CCN: 15-S104	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part II Date/Time Prepared: 5/26/2017 10:44 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2,237,974	1.00
2.00	Net IPF PPS Outlier Payments	9,353	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	7.527322	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,247,327	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,247,327	16.00
17.00	Primary payer payments	15,926	17.00
18.00	Subtotal (line 16 less line 17).	2,231,401	18.00
19.00	Deductibles	151,844	19.00
20.00	Subtotal (line 18 minus line 19)	2,079,557	20.00
21.00	Coinsurance	8,372	21.00
22.00	Subtotal (line 20 minus line 21)	2,071,185	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	2,071,185	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	2,071,185	31.00
31.01	Sequestration adjustment (see instructions)	41,424	31.01
32.00	Interim payments	2,029,759	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	2	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	9,353	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104 Component CCN: 15-5832	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VI Date/Time Prepared: 5/26/2017 10:44 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,563,768	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,563,768	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	146,139	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1,417,629	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (see instructions	1,417,629	15.00
15.01	Sequestration adjustment (see instructions)	28,353	15.01
16.00	Interim payments	1,389,276	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2017 10:44 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	311,910		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	311,910	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	311,910	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	501,217		8.00
9.00	Ancillary service charges	551,035	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,052,252	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,052,252	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	740,342	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	311,910	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	311,910	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	311,910	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	311,910	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	311,910	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	311,910	0	40.00
41.00	Interim payments	285,224	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	26,686	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 5/26/2017 10:44 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	27,623,969	0	0	0	1.00
2.00	Temporary investments	12,831,683	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	14,059,089	0	0	0	4.00
5.00	Other receivable	2,156,911	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,693,483	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	977,013	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)	60,342,148	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	15,269,174	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	405,853	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	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	137,747,688	0	0	0	23.00
24.00	Accumulated depreciation	-66,499,751	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	86,922,964	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	17,585,925	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	17,585,925	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	164,851,037	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,340,688	0	0	0	37.00
38.00	Salaries, wages, and fees payable	8,202,966	0	0	0	38.00
39.00	Payroll taxes payable	0	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	0	0	0	0	43.00
44.00	Other current liabilities	3,607,774	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,151,428	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	56,819,333	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	56,819,333	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	70,970,761	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	93,880,276				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)	93,880,276	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	164,851,037	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 5/26/2017 10:44 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		88,385,599		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,494,677				2.00
3.00	Total (sum of line 1 and line 2)		93,880,276		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		93,880,276		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		93,880,276		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/26/2017 10:44 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	14,166,951		14,166,951	1.00
2.00	SUBPROVIDER - IPF	3,008,160		3,008,160	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	2,210,215		2,210,215	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)	19,385,326		19,385,326	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,671,401		3,671,401	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)	3,671,401		3,671,401	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	23,056,727		23,056,727	17.00
18.00	Ancillary services	47,433,215	181,787,899	229,221,114	18.00
19.00	Outpatient services	3,544,150	33,435,123	36,979,273	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	13,858	6,261,037	6,274,895	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	EH&S, DIETARY, PHYSICIAN PRIVATE OFF	2,886	42,880,024	42,882,910	27.00
27.01	PROFESSIONAL FEE	0	3,675,813	3,675,813	27.01
27.02	SELF-INSURED	1,098,719	5,714,631	6,813,350	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	75,149,555	273,754,527	348,904,082	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		119,641,030		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)		119,641,030		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0104 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-3 | Date/Time Prepared: 5/26/2017 10:44 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	348,904,082	1.00
2.00	Less contractual allowances and discounts on patients' accounts	230,669,234	2.00
3.00	Net patient revenues (line 1 minus line 2)	118,234,848	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	119,641,030	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,406,182	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 OPERATING INCOME	4,083,884	24.00
24.01	NON-OPERATING INCOME	2,816,975	24.01
25.00	Total other income (sum of lines 6-24)	6,900,859	25.00
26.00	Total (line 5 plus line 25)	5,494,677	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)	5,494,677	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0104	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 5/26/2017 10:44 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	464,120	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	242	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)	19.15	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)	464,362	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