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: 15-1311	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/24/2017 10:02 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/24/2017 Time: 10:02 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH TIPTON HOSPITAL (15-1311) 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)

PRESIDENT
Title

05/25/2017
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	-162,820	-233,830	1	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-239,894	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-402,714	-233,830	1	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2017 9:10 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1000 SOUTH MAIN STREET	PO Box:			1.00
2.00	City: TIPTON	State: IN	Zip Code: 46072	County: TIPTON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	IU HEALTH TIPTON HOSPITAL	151311	99915	1	11/12/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	IU HEALTH TIPTON HOSPITAL	15Z311	29020		11/12/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2017 9:10 am

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2017 9:10 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: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2017 9:10 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1311	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/24/2017 9:10 am

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	55,883	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.	Y	5.03	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: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2017 9:10 am

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	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: INDIANA UNIVERSITY HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST 10TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46202	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	1	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1311	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/24/2017 9:10 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)	10/01/2016	12/31/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	Y	77	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2017 9:10 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	C	03/25/2016	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.	Y	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/03/2017	Y	04/03/2017	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: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 5/24/2017 9:10 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA		UTTER		41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.962.1093		RUTTER@IUHEALTH.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1311	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/24/2017 9:10 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR OF GOVERNMENT PROGRAMS		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: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/24/2017 9:10 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	19	6,954	50,544.00	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)		19	6,954	50,544.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,196	10,800.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,150	61,344.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				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: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2017 9:10 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)	1,411	4	2,106			1.00
2.00	HMO and other (see instructions)	376	123				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	674	0	674			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	112			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,085	4	2,892			7.00
8.00	INTENSIVE CARE UNIT	211	0	450			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)	2,296	4	3,342	0.00	168.05	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	168.05	27.00
28.00	Observation Bed Days		48	670			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2017 9:10 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	475	2	893	1.00
2.00	HMO and other (see instructions)			88	6		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	475	2	893	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 5/24/2017 9:10 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)	0.287612	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	777,992	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	11,277,902	6.00
7.00	Medicaid cost (line 1 times line 6)	3,243,660	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,465,668	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,465,668	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	1,811,801	108,623	1,920,424	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	521,096	31,241	552,337	21.00
22.00	Partial payment by patients approved for charity care	58,336	44,610	102,946	22.00
23.00	Cost of charity care (line 21 minus line 22)	462,760	-13,369	449,391	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)	951,460	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	511,660	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	439,800	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	126,492	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	575,883	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,041,551	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/24/2017 9:10 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,387,364	1,387,364	-884,251	503,113	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES		818,811	818,811	0	818,811	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	884,251	884,251	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	154,677	2,439,912	2,594,589	-3	2,594,586	4.00
5.01	01160	COMMUNICATIONS	0	0	0	323,359	323,359	5.01
5.02	00550	PATIENT ACCOUNTING	0	23,203	23,203	0	23,203	5.02
5.03	00591	OTHER ADMINISTRATIVE AND GENERAL	887,376	5,677,274	6,564,650	-517,505	6,047,145	5.03
7.00	00700	OPERATION OF PLANT	405,201	3,216,544	3,621,745	4,809	3,626,554	7.00
7.01	00701	OPERATION OF PLANT- OFFSITE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	48,245	55,228	103,473	0	103,473	8.00
9.00	00900	HOUSEKEEPING	265,148	91,768	356,916	-35,391	321,525	9.00
10.00	01000	DIETARY	410,686	211,515	622,201	-262,394	359,807	10.00
11.00	01100	CAFETERIA	0	0	0	262,344	262,344	11.00
13.00	01300	NURSING ADMINISTRATION	379,867	12,314	392,181	157,538	549,719	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,095	2,396	16,491	1,050,198	1,066,689	14.00
15.00	01500	PHARMACY	543,158	2,164,448	2,707,606	-1,637,924	1,069,682	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,195,297	130,071	1,325,368	-75,951	1,249,417	30.00
31.00	03100	INTENSIVE CARE UNIT	717,133	28,675	745,808	-25,533	720,275	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,084,943	2,672,801	3,757,744	-2,206,071	1,551,673	50.00
53.00	05300	ANESTHESIOLOGY	193,695	308,822	502,517	-10,528	491,989	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,021,434	308,202	1,329,636	-101,787	1,227,849	54.00
60.00	06000	LABORATORY	0	1,342,539	1,342,539	0	1,342,539	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	410,536	64,910	475,446	-22,992	452,454	65.00
66.00	06600	PHYSICAL THERAPY	599,212	59,914	659,126	-42,889	616,237	66.00
67.00	06700	OCCUPATIONAL THERAPY	220,864	49,003	269,867	17,975	287,842	67.00
69.00	06900	ELECTROCARDIOLOGY	396,788	61,690	458,478	-19,946	438,532	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	189,925	189,925	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,385,682	1,385,682	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,816,921	1,816,921	73.00
73.01	03480	ONCOLOGY	178,759	28,503	207,262	-14,035	193,227	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	67,558	18,366	85,924	-1,087	84,837	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,071,335	1,256,381	2,327,716	-83,874	2,243,842	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,266,007	22,430,654	32,696,661	150,841	32,847,502	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	0	24,646	24,646	0	24,646	190.01
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	MEALS ON WHEELS	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	76,337	452,916	529,253	-138,421	390,832	192.00
192.01	19201	OCCUPATIONAL MEDICINE	32,839	57,889	90,728	-12,420	78,308	192.01
194.00	07950	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	VACANT SPACE	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	10,375,183	22,966,105	33,341,288	0	33,341,288	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/24/2017 9:10 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	832,072	1,335,185		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES	-115,427	703,384		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	211,962	1,096,213		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-447,336	2,147,250		4.00
5.01	01160	COMMUNICATIONS	-8,014	315,345		5.01
5.02	00550	PATIENT ACCOUNTING	-55	23,148		5.02
5.03	00591	OTHER ADMINISTRATIVE AND GENERAL	-436,935	5,610,210		5.03
7.00	00700	OPERATION OF PLANT	0	3,626,554		7.00
7.01	00701	OPERATION OF PLANT- OFFSITE	0	0		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	103,473		8.00
9.00	00900	HOUSEKEEPING	-20	321,505		9.00
10.00	01000	DIETARY	0	359,807		10.00
11.00	01100	CAFETERIA	-66,658	195,686		11.00
13.00	01300	NURSING ADMINISTRATION	-645	549,074		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,066,689		14.00
15.00	01500	PHARMACY	-300,628	769,054		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-13,350	1,236,067		30.00
31.00	03100	INTENSIVE CARE UNIT	0	720,275		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-356,391	1,195,282		50.00
53.00	05300	ANESTHESIOLOGY	-443,695	48,294		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-150,749	1,077,100		54.00
60.00	06000	LABORATORY	-5,250	1,337,289		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	-16,308	436,146		65.00
66.00	06600	PHYSICAL THERAPY	-8,498	607,739		66.00
67.00	06700	OCCUPATIONAL THERAPY	-2,050	285,792		67.00
69.00	06900	ELECTROCARDIOLOGY	-17,564	420,968		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	189,925		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,385,682		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-4	1,816,917		73.00
73.01	03480	ONCOLOGY	0	193,227		73.01
76.00	03160	CARDIOPULMONARY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	84,837		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-734,932	1,508,910		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,080,475	30,767,027		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	0	24,646		190.01
191.00	19100	RESEARCH	0	0		191.00
191.01	19101	MEALS ON WHEELS	0	0		191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	390,832		192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	78,308		192.01
194.00	07950	COMMUNITY FITNESS CENTER	0	0		194.00
194.01	07951	VACANT SPACE	0	0		194.01
200.00		TOTAL (SUM OF LINES 118-199)	-2,080,475	31,260,813		200.00

RECLASSIFICATIONS | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/24/2017 9:10 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DIETARY/CAFETERIA				
1.00	CAFETERIA	11.00	173,175	89,169	1.00
	0		173,175	89,169	
	B - VICE PRESIDENT OF NURSING				
1.00	NURSING ADMINISTRATION	13.00	157,800	0	1.00
	0		157,800	0	
	C - SUPPLIES COSTS				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,050,198	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	189,925	2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,385,682	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
	0		0	2,625,805	
	D - DRUGS COSTS				
1.00	PHARMACY	15.00	0	117,508	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,816,921	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
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
	0		0	1,934,429	
	E - EQUIPMENT DEPRECIATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	884,251	1.00
	0		0	884,251	
	F - ORTHOPEDIC CLERICAL STAFF				
1.00	OCCUPATIONAL THERAPY	67.00	17,975	0	1.00
	0		17,975	0	
	G - UTILITIES COSTS				
1.00	COMMUNICATIONS	5.01	0	4,050	1.00
2.00	OPERATION OF PLANT	7.00	0	10,977	2.00
3.00		0.00	0	0	3.00
	0		0	15,027	
	H - COMMUNICATION CLERKS				
1.00	COMMUNICATIONS	5.01	319,309	0	1.00
	0		319,309	0	
	I - SURGERY ON CALL				
1.00	OPERATING ROOM	50.00	0	113,786	1.00
	TOTALS		0	113,786	
500.00	Grand Total: Increases		668,259	5,662,467	500.00

RECLASSIFICATIONS | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/24/2017 9:10 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DIETARY/CAFETERIA						
1.00	DIETARY	10.00	173,175	89,169	0		1.00
	0		173,175	89,169			
	B - VICE PRESIDENT OF NURSING						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	157,800	0	0		1.00
	0		157,800	0			
	C - SUPPLIES COSTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3	0		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	13,028	0		2.00
3.00	OPERATION OF PLANT	7.00	0	6,166	0		3.00
4.00	HOUSEKEEPING	9.00	0	35,391	0		4.00
5.00	DIETARY	10.00	0	45	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	262	0		6.00
7.00	PHARMACY	15.00	0	5,435	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	65,695	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	22,083	0		9.00
10.00	OPERATING ROOM	50.00	0	2,303,474	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	26,931	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	22,769	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	24,237	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	11,108	0		14.00
15.00	ONCOLOGY	73.01	0	11,326	0		15.00
16.00	CARDIAC REHABILITATION	76.97	0	1,082	0		16.00
17.00	EMERGENCY	91.00	0	64,482	0		17.00
18.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	11,062	0		18.00
19.00	OCCUPATIONAL MEDICINE	192.01	0	1,226	0		19.00
	0		0	2,625,805			
	D - DRUGS COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	26,082	0		1.00
2.00	OPERATION OF PLANT	7.00	0	2	0		2.00
3.00	DIETARY	10.00	0	5	0		3.00
4.00	PHARMACY	15.00	0	1,749,997	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	10,256	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	3,450	0		6.00
7.00	OPERATING ROOM	50.00	0	16,383	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	10,528	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	74,856	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	223	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	48	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	8,838	0		12.00
13.00	ONCOLOGY	73.01	0	2,709	0		13.00
14.00	CARDIAC REHABILITATION	76.97	0	5	0		14.00
15.00	EMERGENCY	91.00	0	19,392	0		15.00
16.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	461	0		16.00
17.00	OCCUPATIONAL MEDICINE	192.01	0	11,194	0		17.00
	0		0	1,934,429			
	E - EQUIPMENT DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	884,251	9		1.00
	0		0	884,251			
	F - ORTHOPEDIC CLERICAL STAFF						
1.00	PHYSICAL THERAPY	66.00	17,975	0	0		1.00
	0		17,975	0			
	G - UTILITIES COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	1,286	0		1.00
2.00	PHYSICAL THERAPY	66.00	0	629	0		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	13,112	0		3.00
	0		0	15,027			
	H - COMMUNICATION CLERKS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	319,309	0	0		1.00
	0		319,309	0			
	I - SURGERY ON CALL						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	113,786	0		1.00
	TOTALS		0	113,786			
500.00	Grand Total: Decreases		668,259	5,662,467			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 5/24/2017 9:10 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	31,500	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	30,401,084	0	0	0	0	3.00
4.00	Building Improvements	8,633,678	0	0	0	0	4.00
5.00	Fixed Equipment	12,029,575	0	0	0	0	5.00
6.00	Movable Equipment	17,449,292	185,433	0	185,433	276,665	6.00
7.00	HIT designated Assets	1,137,296	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	69,682,425	185,433	0	185,433	276,665	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	69,682,425	185,433	0	185,433	276,665	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	31,500	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	30,401,084	2,377,541	3.00
4.00	Building Improvements	8,633,678	111,137	4.00
5.00	Fixed Equipment	12,029,575	9,459,866	5.00
6.00	Movable Equipment	17,358,060	12,263,521	6.00
7.00	HIT designated Assets	1,137,296	0	7.00
8.00	Subtotal (sum of lines 1-7)	69,591,193	24,212,065	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	69,591,193	24,212,065	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part II Date/Time Prepared: 5/24/2017 9:10 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,387,364	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	818,811	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,387,364	0	818,811	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,387,364	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	818,811	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	2,206,175	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 5/24/2017 9:10 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	503,113	0	503,113	0.228048	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	818,811	0	818,811	0.371145	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	884,251	0	884,251	0.400807	0	2.00
3.00	Total (sum of lines 1-2)	2,206,175	0	2,206,175	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,335,185	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	974,720	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,309,905	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,335,185	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	703,384	0	0	0	703,384	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	121,493	0	0	0	1,096,213	2.00
3.00	Total (sum of lines 1-2)	824,877	0	0	0	3,134,782	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/24/2017 9:10 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - INTERES (chapter 2)	B	-115,427	CAP REL COSTS-BLDG & FIXT - INTERES	1.01	11	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,524,537			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	1,769,488			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-66,658	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	A	-300,626	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-55	PATIENT ACCOUNTING	5.02	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	861,010	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - INTERES		0	CAP REL COSTS-BLDG & FIXT - INTERES	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	165,118	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/24/2017 9:10 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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-90,125	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	ASSISTED LIVING BLDG DEPRECIATION	A	-146,373	CAP REL COSTS-BLDG & FIXT	1.00	9	33.00
33.01	HAF FEES	A	-512,964	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.01
33.03	CRNA SALARY	A	-193,695	ANESTHESIOLOGY	53.00	0	33.03
33.04	CRNA BENEFITS	A	-49,692	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.06	MISCELLANEOUS REVENUE	B	-4,412	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.06
33.07	MISCELLANEOUS REVENUE	B	-475	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.07
33.08	MISCELLANEOUS REVENUE - RADIOLOGY	B	-343	RADIOLOGY-DIAGNOSTIC	54.00	0	33.08
33.09	MISC REVENUE - SPORTS MEDICINE	B	-2,050	OCCUPATIONAL THERAPY	67.00	0	33.09
33.10	MISCELLANEOUS REVENUE - SLEEP LAB	B	-17,553	ELECTROCARDIOLOGY	69.00	0	33.10
33.11	EDUCATION SERVICES	B	-645	NURSING ADMINISTRATION	13.00	0	33.11
33.12	INVESTMENT FEES	A	9,528	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.12
33.16	PATIENT PHONES - SALARY	A	-8,014	COMMUNICATIONS	5.01	0	33.16
33.17	PATIENT PHONES - BENEFITS	A	-2,056	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
33.18	EMPLOYEE BENEFITS	A	-1,716,967	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.18
33.19	MISCELLANEOUS REVENUE	B	-11,305	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.19
33.20	MISCELLANEOUS REVENUE	B	-20	HOUSEKEEPING	9.00	0	33.20
33.21	MISCELLANEOUS REVENUE	B	-2,580	RESPIRATORY THERAPY	65.00	0	33.21
33.22	MISCELLANEOUS REVENUE	B	-8,498	PHYSICAL THERAPY	66.00	0	33.22
33.23	MISCELLANEOUS REVENUE	B	-4	DRUGS CHARGED TO PATIENTS	73.00	0	33.23
33.24	EMPLOYEE BENEFITS	A	-2	PHARMACY	15.00	0	33.24
33.25	EMPLOYEE BENEFITS	A	-20	RADIOLOGY-DIAGNOSTIC	54.00	0	33.25
33.26	EMPLOYEE BENEFITS	A	-11	ELECTROCARDIOLOGY	69.00	0	33.26
34.00	ACCRUED PTO EXPENSE	A	-126,018	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.00
34.01	LEASE DEPRECIATION - CARRY FORWARD	A	30	CAP REL COSTS-BLDG & FIXT	1.00	9	34.01
34.02	EQUIPMENT DEPRECIATION - CARRY FORWA	A	15,476	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.02
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,080,475				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/24/2017 9:10 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	BUILDING DEPRECIATION (HO)	117,405	0	1.00
2.00	1.01	CAP REL COSTS-BLDG & FIXT -	INTEREST EXPENSE (HO)	821,792	821,792	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	EQUIPMENT DEPRECIATION (HO)	121,493	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS	1,487,360	28,658	4.00
4.01	5.03	OTHER ADMINISTRATIVE AND GEN	OTHER A&G (HO)	4,929,678	4,857,790	4.01
4.02	7.00	OPERATION OF PLANT	FACILITIES (SLA)	123,424	123,424	4.02
4.03	10.00	DIETARY	DIETARY (SLA)	10,335	10,335	4.03
4.04	13.00	NURSING ADMINISTRATION	NURSING ADMIN (SLA)	50,487	50,487	4.04
4.05	14.00	CENTRAL SERVICES & SUPPLY	MATERIALS MANAGEMENT (SLA)	14,095	14,095	4.05
4.06	50.00	OPERATING ROOM	OPERATING ROOM (SLA)	96,126	96,126	4.06
4.07	54.00	RADIOLOGY-DIAGNOSTIC	RADIOLOGY (SLA)	150,386	150,386	4.07
4.08	60.00	LABORATORY	LABORATORY (SLA)	1,312,126	1,312,126	4.08
4.09	65.00	RESPIRATORY THERAPY	RESP THERAPY (SLA)	13,728	13,728	4.09
4.10	69.00	ELECTROCARDIOLOGY	SLEEP LAB (SLA)	182,811	182,811	4.10
4.11	91.00	EMERGENCY	EMERGENCY (SLA)	1,184,888	1,184,888	4.11
4.12	190.01	MARKETING/PUBLIC RELATIONS	MARKETING (SLA)	24,606	24,606	4.12
4.13	192.00	PHYSICIANS' PRIVATE OFFICES	PHYSICIAN SERVICES (SLA)	191,669	191,669	4.13
4.14	192.01	OCCUPATIONAL MEDICINE	OCCUPATIONAL HEALTH (SLA)	33,360	33,360	4.14
4.15	0.00			0	0	4.15
4.16	0.00			0	0	4.16
4.17	0.00			0	0	4.17
4.18	0.00			0	0	4.18
4.19	0.00			0	0	4.19
4.20	0.00			0	0	4.20
4.21	0.00			0	0	4.21
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			10,865,769	9,096,281	5.00

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

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

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

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

6.00	B	IU HEALTH	100.00		0.00	6.00
7.00	B	IUH NORTH HOSP	1.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/24/2017 9:10 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	117,405	9		1.00
2.00	0	9		2.00
3.00	121,493	11		3.00
4.00	1,458,702	9		4.00
4.01	71,888	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	0	0		4.21
5.00	1,769,488			5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2017 9:10 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.03	OTHER ADMINISTRATIVE AND GENERAL	500	500	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	13,350	13,350	0	0	0	2.00
3.00	50.00	OPERATING ROOM	356,391	356,391	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	304,133	250,000	54,133	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	150,386	150,386	0	0	0	5.00
6.00	60.00	LABORATORY	9,488	5,250	4,238	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	13,728	13,728	0	0	0	7.00
8.00	67.00	OCCUPATIONAL THERAPY	6,000	0	6,000	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	25,172	0	25,172	0	0	9.00
10.00	91.00	EMERGENCY	1,142,783	734,932	407,851	0	0	10.00
200.00			2,021,931	1,524,537	497,394		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.03	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.03	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	500		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	13,350		2.00
3.00	50.00	OPERATING ROOM	0	0	0	356,391		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	250,000		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	150,386		5.00
6.00	60.00	LABORATORY	0	0	0	5,250		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	13,728		7.00
8.00	67.00	OCCUPATIONAL THERAPY	0	0	0	0		8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0		9.00
10.00	91.00	EMERGENCY	0	0	0	734,932		10.00
200.00			0	0	0	1,524,537		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/24/2017 9:10 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - INTERES	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,335,185	1,335,185				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES	703,384	0	703,384			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,096,213			1,096,213		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,147,250	11,139	6,983	9,308	2,174,680	4.00
5.01	01160	COMMUNICATIONS	315,345	16,422	10,295	13,723	69,254	5.01
5.02	00550	PATIENT ACCOUNTING	23,148	41,099	25,766	34,344	0	5.02
5.03	00591	OTHER ADMINISTRATIVE AND GENERAL	5,610,210	28,806	18,059	24,071	88,982	5.03
7.00	00700	OPERATION OF PLANT	3,626,554	272,793	139,228	227,957	87,883	7.00
7.01	00701	OPERATION OF PLANT- OFFSITE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	103,473	20,795	13,036	17,377	10,464	8.00
9.00	00900	HOUSEKEEPING	321,505	11,023	6,910	9,211	57,507	9.00
10.00	01000	DIETARY	359,807	32,031	20,080	26,766	51,596	10.00
11.00	01100	CAFETERIA	195,686	22,278	13,967	18,617	37,476	11.00
13.00	01300	NURSING ADMINISTRATION	549,074	29,451	14,529	24,610	116,613	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,066,689	30,425	19,074	25,424	3,057	14.00
15.00	01500	PHARMACY	769,054	10,378	6,506	8,672	117,804	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,236,067	99,175	62,174	82,874	259,238	30.00
31.00	03100	INTENSIVE CARE UNIT	720,275	26,084	16,352	21,797	155,537	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,195,282	158,050	99,084	132,073	235,310	50.00
53.00	05300	ANESTHESIOLOGY	48,294	2,902	1,820	2,425	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,077,100	80,754	50,626	67,481	221,536	54.00
60.00	06000	LABORATORY	1,337,289	33,082	20,739	27,644	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	436,146	1,935	1,213	1,617	89,040	65.00
66.00	06600	PHYSICAL THERAPY	607,739	42,183	26,445	35,250	126,063	66.00
67.00	06700	OCCUPATIONAL THERAPY	285,792	6,837	4,286	5,713	51,801	67.00
69.00	06900	ELECTROCARDIOLOGY	420,968	19,692	12,345	16,455	86,058	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	189,925	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,385,682	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,816,917	0	0	0	0	73.00
73.01	03480	ONCOLOGY	193,227	12,829	8,043	10,720	38,771	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	84,837	14,603	9,155	12,203	14,652	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,508,910	93,409	58,559	78,056	232,359	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,767,027	1,118,175	665,274	934,388	2,151,001	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	24,646	4,799	3,008	4,010	0	190.01
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	MEALS ON WHEELS	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	390,832	179,497	25,426	149,994	16,557	192.00
192.01	19201	OCCUPATIONAL MEDICINE	78,308	9,359	5,867	7,821	7,122	192.01
194.00	07950	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	VACANT SPACE	0	23,355	3,809	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	31,260,813	1,335,185	703,384	1,096,213	2,174,680	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/24/2017 9:10 am

		Cost Center Description	COMMUNICATIONS	PATIENT ACCOUNTING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	
			5.01	5.02	5A.02	5.03	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS	425,039					5.01
5.02	00550	PATIENT ACCOUNTING	48,149	172,506				5.02
5.03	00591	OTHER ADMINISTRATIVE AND GENERAL	54,789	0	5,824,917	5,824,917		5.03
7.00	00700	OPERATION OF PLANT	31,546	0	4,385,961	1,004,398	5,390,359	7.00
7.01	00701	OPERATION OF PLANT- OFFSITE	0	0	0	0	322,734	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	165,145	37,819	132,328	8.00
9.00	00900	HOUSEKEEPING	0	0	406,156	93,011	70,145	9.00
10.00	01000	DIETARY	4,981	0	495,261	113,417	203,828	10.00
11.00	01100	CAFETERIA	3,321	0	291,345	66,719	141,768	11.00
13.00	01300	NURSING ADMINISTRATION	34,866	0	769,143	176,137	147,474	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,641	0	1,151,310	263,655	193,608	14.00
15.00	01500	PHARMACY	8,302	0	920,716	210,848	66,041	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,565	3,493	1,769,586	405,242	631,103	30.00
31.00	03100	INTENSIVE CARE UNIT	14,943	762	955,750	218,871	165,985	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	38,187	42,392	1,900,378	435,194	1,005,762	50.00
53.00	05300	ANESTHESIOLOGY	0	1,471	56,912	13,033	18,470	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,584	17,236	1,536,317	351,823	513,880	54.00
60.00	06000	LABORATORY	21,584	12,957	1,453,295	332,810	210,518	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	8,302	2,106	540,359	123,744	12,313	65.00
66.00	06600	PHYSICAL THERAPY	26,565	4,230	868,475	198,884	268,432	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,641	1,243	362,313	82,971	43,507	67.00
69.00	06900	ELECTROCARDIOLOGY	23,244	7,445	586,207	134,244	125,309	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,038	193,963	44,418	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,946	1,404,628	321,665	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,837	1,835,754	420,395	0	73.00
73.01	03480	ONCOLOGY	9,962	3,164	276,716	63,369	81,638	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,036	136,486	31,256	92,925	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	19,924	33,150	2,024,367	463,588	594,409	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	410,096	172,506	30,311,460	5,607,511	5,042,177	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,321	0	3,321	761	0	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	4,981	0	41,444	9,491	30,537	190.01
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	MEALS ON WHEELS	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	762,306	174,571	258,089	192.00
192.01	19201	OCCUPATIONAL MEDICINE	6,641	0	115,118	26,362	59,556	192.01
194.00	07950	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	VACANT SPACE	0	0	27,164	6,221	0	194.01
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)	425,039	172,506	31,260,813	5,824,917	5,390,359	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/24/2017 9:10 am

		Cost Center Description	OPERATION OF PLANT- OFFSITE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.01	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	PATIENT ACCOUNTING						5.02
5.03	00591	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT- OFFSITE	322,734					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	335,292				8.00
9.00	00900	HOUSEKEEPING	0	0	569,312			9.00
10.00	01000	DIETARY	0	0	22,007	834,513		10.00
11.00	01100	CAFETERIA	0	0	15,307	0	515,139	11.00
13.00	01300	NURSING ADMINISTRATION	13,935	0	15,923	0	19,226	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	20,904	0	0	14.00
15.00	01500	PHARMACY	0	0	7,130	0	24,689	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	46,803	68,141	722,137	88,968	30.00
31.00	03100	INTENSIVE CARE UNIT	0	41,584	17,921	112,376	39,872	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	43,157	108,593	0	57,360	50.00
53.00	05300	ANESTHESIOLOGY	0	0	1,994	0	3,547	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	56,406	55,484	0	56,260	54.00
60.00	06000	LABORATORY	0	6,291	22,730	0	45,299	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,329	0	23,093	65.00
66.00	06600	PHYSICAL THERAPY	0	22,782	28,983	0	32,706	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	4,698	0	15,785	67.00
69.00	06900	ELECTROCARDIOLOGY	0	44,729	13,530	0	16,105	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	8,814	0	9,223	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	16,681	10,033	0	3,334	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	42,775	64,179	0	69,385	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,935	321,208	487,700	834,513	504,852	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	0	0	3,297	0	0	190.01
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	MEALS ON WHEELS	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	308,799	14,084	71,885	0	6,882	192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	0	6,430	0	3,405	192.01
194.00	07950	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	VACANT SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	322,734	335,292	569,312	834,513	515,139	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/24/2017 9:10 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	14.00	15.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	PATIENT ACCOUNTING						5.02
5.03	00591	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT- OFFSITE						7.01
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	1,141,838					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,629,477				14.00
15.00	01500	PHARMACY	0	3,627	1,233,051			15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	295,227	40,065	0	4,067,272	0	30.00
31.00	03100	INTENSIVE CARE UNIT	132,338	13,239	0	1,697,936	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	190,326	459,273	0	4,200,043	0	50.00
53.00	05300	ANESTHESIOLOGY	11,772	0	0	105,728	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	186,744	15,531	0	2,772,445	0	54.00
60.00	06000	LABORATORY	0	28,398	0	2,099,341	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	14,180	0	715,018	0	65.00
66.00	06600	PHYSICAL THERAPY	0	14,900	0	1,435,162	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	509,274	0	67.00
69.00	06900	ELECTROCARDIOLOGY	53,438	6,918	0	980,480	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	118,279	0	356,660	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	862,958	0	2,589,251	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,233,051	3,489,200	0	73.00
73.01	03480	ONCOLOGY	30,601	7,025	0	477,386	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	11,081	674	0	302,470	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	230,311	36,883	0	3,525,897	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,141,838	1,621,950	1,233,051	29,323,563	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	4,082	0	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	0	0	0	84,769	0	190.01
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	MEALS ON WHEELS	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,857	0	1,603,473	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	670	0	211,541	0	192.01
194.00	07950	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	VACANT SPACE	0	0	0	33,385	0	194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,141,838	1,629,477	1,233,051	31,260,813	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/24/2017 9:10 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	01160	COMMUNICATIONS			5.01
5.02	00550	PATIENT ACCOUNTING			5.02
5.03	00591	OTHER ADMINISTRATIVE AND GENERAL			5.03
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT- OFFSITE			7.01
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	4,067,272		30.00
31.00	03100	INTENSIVE CARE UNIT	1,697,936		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	4,200,043		50.00
53.00	05300	ANESTHESIOLOGY	105,728		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,772,445		54.00
60.00	06000	LABORATORY	2,099,341		60.00
64.00	06400	INTRAVENOUS THERAPY	0		64.00
65.00	06500	RESPIRATORY THERAPY	715,018		65.00
66.00	06600	PHYSICAL THERAPY	1,435,162		66.00
67.00	06700	OCCUPATIONAL THERAPY	509,274		67.00
69.00	06900	ELECTROCARDIOLOGY	980,480		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	356,660		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,589,251		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,489,200		73.00
73.01	03480	ONCOLOGY	477,386		73.01
76.00	03160	CARDIOPULMONARY	0		76.00
76.97	07697	CARDIAC REHABILITATION	302,470		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	3,525,897		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,323,563		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,082		190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	84,769		190.01
191.00	19100	RESEARCH	0		191.00
191.01	19101	MEALS ON WHEELS	0		191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,603,473		192.00
192.01	19201	OCCUPATIONAL MEDICINE	211,541		192.01
194.00	07950	COMMUNITY FITNESS CENTER	0		194.00
194.01	07951	VACANT SPACE	33,385		194.01
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	31,260,813		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/24/2017 9:10 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS BLDG & FIXT - INTERES	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	11,139	6,983	9,308	27,430	4.00
5.01	01160	COMMUNICATIONS	0	16,422	10,295	13,723	40,440	5.01
5.02	00550	PATIENT ACCOUNTING	0	41,099	25,766	34,344	101,209	5.02
5.03	00591	OTHER ADMINISTRATIVE AND GENERAL	0	28,806	18,059	24,071	70,936	5.03
7.00	00700	OPERATION OF PLANT	0	272,793	139,228	227,957	639,978	7.00
7.01	00701	OPERATION OF PLANT- OFFSITE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	20,795	13,036	17,377	51,208	8.00
9.00	00900	HOUSEKEEPING	0	11,023	6,910	9,211	27,144	9.00
10.00	01000	DIETARY	0	32,031	20,080	26,766	78,877	10.00
11.00	01100	CAFETERIA	0	22,278	13,967	18,617	54,862	11.00
13.00	01300	NURSING ADMINISTRATION	0	29,451	14,529	24,610	68,590	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	30,425	19,074	25,424	74,923	14.00
15.00	01500	PHARMACY	0	10,378	6,506	8,672	25,556	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	99,175	62,174	82,874	244,223	30.00
31.00	03100	INTENSIVE CARE UNIT	0	26,084	16,352	21,797	64,233	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	158,050	99,084	132,073	389,207	50.00
53.00	05300	ANESTHESIOLOGY	0	2,902	1,820	2,425	7,147	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	80,754	50,626	67,481	198,861	54.00
60.00	06000	LABORATORY	0	33,082	20,739	27,644	81,465	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,935	1,213	1,617	4,765	65.00
66.00	06600	PHYSICAL THERAPY	0	42,183	26,445	35,250	103,878	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,837	4,286	5,713	16,836	67.00
69.00	06900	ELECTROCARDIOLOGY	0	19,692	12,345	16,455	48,492	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	12,829	8,043	10,720	31,592	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	14,603	9,155	12,203	35,961	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	93,409	58,559	78,056	230,024	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,118,175	665,274	934,388	2,717,837	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	0	4,799	3,008	4,010	11,817	190.01
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	MEALS ON WHEELS	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	179,497	25,426	149,994	354,917	192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	9,359	5,867	7,821	23,047	192.01
194.00	07950	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	VACANT SPACE	0	23,355	3,809	0	27,164	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,335,185	703,384	1,096,213	3,134,782	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/24/2017 9:10 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	PATIENT ACCOUNTING	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	
			4.00	5.01	5.02	5.03	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	27,430					4.00
5.01	01160	COMMUNICATIONS	874	41,314				5.01
5.02	00550	PATIENT ACCOUNTING	0	4,680	105,889			5.02
5.03	00591	OTHER ADMINISTRATIVE AND GENERAL	1,122	5,325	0	77,383		5.03
7.00	00700	OPERATION OF PLANT	1,109	3,066	0	13,350	657,503	7.00
7.01	00701	OPERATION OF PLANT- OFFSITE	0	0	0	0	39,366	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	132	0	0	502	16,141	8.00
9.00	00900	HOUSEKEEPING	725	0	0	1,236	8,556	9.00
10.00	01000	DIETARY	651	484	0	1,507	24,862	10.00
11.00	01100	CAFETERIA	473	323	0	886	17,293	11.00
13.00	01300	NURSING ADMINISTRATION	1,471	3,389	0	2,340	17,988	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	39	646	0	3,502	23,616	14.00
15.00	01500	PHARMACY	1,486	807	0	2,801	8,056	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,267	2,582	2,143	5,383	76,980	30.00
31.00	03100	INTENSIVE CARE UNIT	1,962	1,452	467	2,907	20,246	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,968	3,712	26,061	5,781	122,680	50.00
53.00	05300	ANESTHESIOLOGY	0	0	902	173	2,253	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,795	2,098	10,575	4,673	62,682	54.00
60.00	06000	LABORATORY	0	2,098	7,950	4,421	25,679	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,123	807	1,292	1,644	1,502	65.00
66.00	06600	PHYSICAL THERAPY	1,590	2,582	2,595	2,642	32,743	66.00
67.00	06700	OCCUPATIONAL THERAPY	653	646	762	1,102	5,307	67.00
69.00	06900	ELECTROCARDIOLOGY	1,086	2,259	4,568	1,783	15,285	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,477	590	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	11,624	4,273	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	11,557	5,584	0	73.00
73.01	03480	ONCOLOGY	489	968	1,941	842	9,958	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	185	0	636	415	11,335	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,931	1,937	20,339	6,158	72,505	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,131	39,861	105,889	74,495	615,033	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	323	0	10	0	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	0	484	0	126	3,725	190.01
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	MEALS ON WHEELS	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	209	0	0	2,319	31,481	192.00
192.01	19201	OCCUPATIONAL MEDICINE	90	646	0	350	7,264	192.01
194.00	07950	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	VACANT SPACE	0	0	0	83	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	27,430	41,314	105,889	77,383	657,503	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/24/2017 9:10 am

		Cost Center Description	OPERATION OF PLANT- OFFSITE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.01	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	PATIENT ACCOUNTING						5.02
5.03	00591	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT- OFFSITE	39,366					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	67,983				8.00
9.00	00900	HOUSEKEEPING	0	0	37,661			9.00
10.00	01000	DIETARY	0	0	1,456	107,837		10.00
11.00	01100	CAFETERIA	0	0	1,013	0	74,850	11.00
13.00	01300	NURSING ADMINISTRATION	1,700	0	1,053	0	2,794	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,383	0	0	14.00
15.00	01500	PHARMACY	0	0	472	0	3,587	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	9,490	4,508	93,316	12,928	30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,431	1,186	14,521	5,793	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	8,750	7,182	0	8,334	50.00
53.00	05300	ANESTHESIOLOGY	0	0	132	0	515	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,437	3,670	0	8,175	54.00
60.00	06000	LABORATORY	0	1,276	1,504	0	6,582	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	88	0	3,355	65.00
66.00	06600	PHYSICAL THERAPY	0	4,619	1,917	0	4,752	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	311	0	2,294	67.00
69.00	06900	ELECTROCARDIOLOGY	0	9,069	895	0	2,340	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	583	0	1,340	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	3,382	664	0	484	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	8,673	4,246	0	10,082	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,700	65,127	32,263	107,837	73,355	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	0	0	218	0	0	190.01
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	MEALS ON WHEELS	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	37,666	2,856	4,755	0	1,000	192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	0	425	0	495	192.01
194.00	07950	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	VACANT SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	39,366	67,983	37,661	107,837	74,850	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/24/2017 9:10 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			13.00	14.00	15.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	PATIENT ACCOUNTING						5.02
5.03	00591	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT- OFFSITE						7.01
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	99,325					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	104,109				14.00
15.00	01500	PHARMACY	0	232	42,997			15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,681	2,560	0	483,061	0	30.00
31.00	03100	INTENSIVE CARE UNIT	11,512	846	0	133,556	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,556	29,343	0	620,574	0	50.00
53.00	05300	ANESTHESIOLOGY	1,024	0	0	12,146	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,244	992	0	322,202	0	54.00
60.00	06000	LABORATORY	0	1,814	0	132,789	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	906	0	15,482	0	65.00
66.00	06600	PHYSICAL THERAPY	0	952	0	158,270	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	27,911	0	67.00
69.00	06900	ELECTROCARDIOLOGY	4,648	442	0	90,867	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,557	0	10,624	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	55,135	0	71,032	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	42,997	60,138	0	73.00
73.01	03480	ONCOLOGY	2,662	449	0	50,824	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	964	43	0	54,069	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	20,034	2,357	0	379,286	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	99,325	103,628	42,997	2,622,831	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	333	0	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	0	0	0	16,370	0	190.01
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	MEALS ON WHEELS	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	438	0	435,641	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	43	0	32,360	0	192.01
194.00	07950	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	VACANT SPACE	0	0	0	27,247	0	194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	99,325	104,109	42,997	3,134,782	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/24/2017 9:10 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	01160	COMMUNICATIONS			5.01
5.02	00550	PATIENT ACCOUNTING			5.02
5.03	00591	OTHER ADMINISTRATIVE AND GENERAL			5.03
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT- OFFSITE			7.01
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	483,061		30.00
31.00	03100	INTENSIVE CARE UNIT	133,556		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	620,574		50.00
53.00	05300	ANESTHESIOLOGY	12,146		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	322,202		54.00
60.00	06000	LABORATORY	132,789		60.00
64.00	06400	INTRAVENOUS THERAPY	0		64.00
65.00	06500	RESPIRATORY THERAPY	15,482		65.00
66.00	06600	PHYSICAL THERAPY	158,270		66.00
67.00	06700	OCCUPATIONAL THERAPY	27,911		67.00
69.00	06900	ELECTROCARDIOLOGY	90,867		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,624		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	71,032		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,138		73.00
73.01	03480	ONCOLOGY	50,824		73.01
76.00	03160	CARDIOPULMONARY	0		76.00
76.97	07697	CARDIAC REHABILITATION	54,069		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	379,286		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,622,831		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	333		190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	16,370		190.01
191.00	19100	RESEARCH	0		191.00
191.01	19101	MEALS ON WHEELS	0		191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	435,641		192.00
192.01	19201	OCCUPATIONAL MEDICINE	32,360		192.01
194.00	07950	COMMUNITY FITNESS CENTER	0		194.00
194.01	07951	VACANT SPACE	27,247		194.01
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	3,134,782		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/24/2017 9:10 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - INTERES (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NON-PATIEN T TELEPHON)	
			1.00	1.01	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	207,006					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES	0	173,951				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			203,385			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,727	1,727	1,727	10,026,811		4.00
5.01	01160	COMMUNICATIONS	2,546	2,546	2,546	319,309	256	5.01
5.02	00550	PATIENT ACCOUNTING	6,372	6,372	6,372	0	29	5.02
5.03	00591	OTHER ADMINISTRATIVE AND GENERAL	4,466	4,466	4,466	410,267	33	5.03
7.00	00700	OPERATION OF PLANT	42,294	34,432	42,294	405,201	19	7.00
7.01	00701	OPERATION OF PLANT- OFFSITE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	3,224	3,224	3,224	48,245	0	8.00
9.00	00900	HOUSEKEEPING	1,709	1,709	1,709	265,148	0	9.00
10.00	01000	DIETARY	4,966	4,966	4,966	237,895	3	10.00
11.00	01100	CAFETERIA	3,454	3,454	3,454	172,791	2	11.00
13.00	01300	NURSING ADMINISTRATION	4,566	3,593	4,566	537,667	21	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,717	4,717	4,717	14,095	4	14.00
15.00	01500	PHARMACY	1,609	1,609	1,609	543,158	5	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,376	15,376	15,376	1,195,297	16	30.00
31.00	03100	INTENSIVE CARE UNIT	4,044	4,044	4,044	717,133	9	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,504	24,504	24,504	1,084,943	23	50.00
53.00	05300	ANESTHESIOLOGY	450	450	450	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,520	12,520	12,520	1,021,434	13	54.00
60.00	06000	LABORATORY	5,129	5,129	5,129	0	13	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	300	300	300	410,536	5	65.00
66.00	06600	PHYSICAL THERAPY	6,540	6,540	6,540	581,237	16	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,060	1,060	1,060	238,839	4	67.00
69.00	06900	ELECTROCARDIOLOGY	3,053	3,053	3,053	396,788	14	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	1,989	1,989	1,989	178,759	6	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,264	2,264	2,264	67,558	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	14,482	14,482	14,482	1,071,335	12	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	173,361	164,526	173,361	9,917,635	247	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	2	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	744	744	744	0	3	190.01
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	MEALS ON WHEELS	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	27,829	6,288	27,829	76,337	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	1,451	1,451	1,451	32,839	4	192.01
194.00	07950	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	VACANT SPACE	3,621	942	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,335,185	703,384	1,096,213	2,174,680	425,039	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.449982	4.043575	5.389842	0.216887	1,660.308594	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				27,430	41,314	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.002736	161.382813	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/24/2017 9:10 am

		Cost Center Description	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT- OFFSITE (SQUARE FEET)	
			5.02	5A.03	5.03	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	PATIENT ACCOUNTING	100,713,921					5.02
5.03	00591	OTHER ADMINISTRATIVE AND GENERAL	0	-5,824,917	25,435,896			5.03
7.00	00700	OPERATION OF PLANT	0	0	4,385,961	131,329		7.00
7.01	00701	OPERATION OF PLANT- OFFSITE	0	0	0	7,863	22,512	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	165,145	3,224	0	8.00
9.00	00900	HOUSEKEEPING	0	0	406,156	1,709	0	9.00
10.00	01000	DIETARY	0	0	495,261	4,966	0	10.00
11.00	01100	CAFETERIA	0	0	291,345	3,454	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	769,143	3,593	972	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,151,310	4,717	0	14.00
15.00	01500	PHARMACY	0	0	920,716	1,609	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,039,035	0	1,769,586	15,376	0	30.00
31.00	03100	INTENSIVE CARE UNIT	444,712	0	955,750	4,044	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,757,883	0	1,900,378	24,504	0	50.00
53.00	05300	ANESTHESIOLOGY	858,511	0	56,912	450	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,061,785	0	1,536,317	12,520	0	54.00
60.00	06000	LABORATORY	7,564,193	0	1,453,295	5,129	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,229,177	0	540,359	300	0	65.00
66.00	06600	PHYSICAL THERAPY	2,469,366	0	868,475	6,540	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	725,453	0	362,313	1,060	0	67.00
69.00	06900	ELECTROCARDIOLOGY	4,345,908	0	586,207	3,053	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,357,173	0	193,963	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,060,297	0	1,404,628	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,996,226	0	1,835,754	0	0	73.00
73.01	03480	ONCOLOGY	1,847,026	0	276,716	1,989	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	605,068	0	136,486	2,264	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	19,352,108	0	2,024,367	14,482	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	100,713,921	-5,824,917	24,486,543	122,846	972	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,321	0	0	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	0	0	41,444	744	0	190.01
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	MEALS ON WHEELS	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	762,306	6,288	21,540	192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	0	115,118	1,451	0	192.01
194.00	07950	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	VACANT SPACE	0	0	27,164	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	172,506		5,824,917	5,390,359	322,734	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001713		0.229004	41.044697	14.336087	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	105,889		77,383	657,503	39,366	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001051		0.003042	5.006533	1.748667	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/24/2017 9:10 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NUR SING HOURS)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	PATIENT ACCOUNTING						5.02
5.03	00591	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT- OFFSITE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE	14,070					8.00
9.00	00900	HOUSEKEEPING	0	128,466				9.00
10.00	01000	DIETARY	0	4,966	14,065			10.00
11.00	01100	CAFETERIA	0	3,454	0	14,522		11.00
13.00	01300	NURSING ADMINISTRATION	0	3,593	0	542	201,753	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,717	0	0	0	14.00
15.00	01500	PHARMACY	0	1,609	0	696	0	15.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,964	15,376	12,171	2,508	52,164	30.00
31.00	03100	INTENSIVE CARE UNIT	1,745	4,044	1,894	1,124	23,383	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,811	24,504	0	1,617	33,629	50.00
53.00	05300	ANESTHESIOLOGY	0	450	0	100	2,080	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,367	12,520	0	1,586	32,996	54.00
60.00	06000	LABORATORY	264	5,129	0	1,277	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	300	0	651	0	65.00
66.00	06600	PHYSICAL THERAPY	956	6,540	0	922	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,060	0	445	0	67.00
69.00	06900	ELECTROCARDIOLOGY	1,877	3,053	0	454	9,442	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	1,989	0	260	5,407	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	700	2,264	0	94	1,958	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,795	14,482	0	1,956	40,694	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,479	110,050	14,065	14,232	201,753	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	0	744	0	0	0	190.01
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	MEALS ON WHEELS	0	0	0	0	0	191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	591	16,221	0	194	0	192.00
192.01	19201	OCCUPATIONAL MEDICINE	0	1,451	0	96	0	192.01
194.00	07950	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	VACANT SPACE	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	335,292	569,312	834,513	515,139	1,141,838	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.830277	4.431616	59.332599	35.473006	5.659584	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	67,983	37,661	107,837	74,850	99,325	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.831770	0.293159	7.667046	5.154249	0.492310	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/24/2017 9:10 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)		
			14.00	15.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - INTERES				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	01160	COMMUNICATIONS				5.01
5.02	00550	PATIENT ACCOUNTING				5.02
5.03	00591	OTHER ADMINISTRATIVE AND GENERAL				5.03
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT- OFFSITE				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,616,509			14.00
15.00	01500	PHARMACY	5,824	100		15.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	64,334	0		30.00
31.00	03100	INTENSIVE CARE UNIT	21,259	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	737,471	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,939	0		54.00
60.00	06000	LABORATORY	45,599	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	22,769	0		65.00
66.00	06600	PHYSICAL THERAPY	23,926	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
69.00	06900	ELECTROCARDIOLOGY	11,108	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	189,925	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,385,682	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100		73.00
73.01	03480	ONCOLOGY	11,280	0		73.01
76.00	03160	CARDIOPULMONARY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	1,082	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	59,225	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,604,423	100		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	MARKETING/PUBLIC RELATIONS	0	0		190.01
191.00	19100	RESEARCH	0	0		191.00
191.01	19101	MEALS ON WHEELS	0	0		191.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,010	0		192.00
192.01	19201	OCCUPATIONAL MEDICINE	1,076	0		192.01
194.00	07950	COMMUNITY FITNESS CENTER	0	0		194.00
194.01	07951	VACANT SPACE	0	0		194.01
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,629,477	1,233,051		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.622768	12,330.510000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	104,109	42,997		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.039789	429.970000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/24/2017 9:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,067,272		4,067,272	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,697,936		1,697,936	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,200,043		4,200,043	0	0	50.00
53.00	05300	ANESTHESIOLOGY	105,728		105,728	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,772,445		2,772,445	0	0	54.00
60.00	06000	LABORATORY	2,099,341		2,099,341	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	715,018	0	715,018	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,435,162	0	1,435,162	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	509,274	0	509,274	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	980,480		980,480	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	356,660		356,660	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,589,251		2,589,251	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,489,200		3,489,200	0	0	73.00
73.01	03480	ONCOLOGY	477,386		477,386	0	0	73.01
76.00	03160	CARDIOPULMONARY	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	302,470		302,470	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	3,525,897		3,525,897	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	786,888		786,888		0	92.00
200.00		Subtotal (see instructions)	30,110,451	0	30,110,451	0	0	200.00
201.00		Less Observation Beds	786,888		786,888		0	201.00
202.00		Total (see instructions)	29,323,563	0	29,323,563	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/24/2017 9:10 am

Title XVIII | 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	2,039,035		2,039,035			30.00
31.00	03100	INTENSIVE CARE UNIT	444,712		444,712			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,831,344	16,926,539	24,757,883	0.169645	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	355,658	502,853	858,511	0.123153	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	497,033	9,582,518	10,079,551	0.275056	0.000000	54.00
60.00	06000	LABORATORY	1,415,020	6,149,173	7,564,193	0.277537	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	512,157	720,283	1,232,440	0.580165	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	869,765	1,599,600	2,469,365	0.581187	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	383,757	341,697	725,454	0.702007	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	276,069	4,069,839	4,345,908	0.225610	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,487,805	869,368	2,357,173	0.151308	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,361,912	1,698,385	11,060,297	0.234103	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,075,184	7,921,042	10,996,226	0.317309	0.000000	73.00
73.01	03480	ONCOLOGY	0	1,847,026	1,847,026	0.258462	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	606,731	606,731	0.498524	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	543,088	18,809,020	19,352,108	0.182197	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	16,371	1,202,271	1,218,642	0.645709	0.000000	92.00
200.00		Subtotal (see instructions)	29,108,910	72,846,345	101,955,255			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	29,108,910	72,846,345	101,955,255			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/24/2017 9:10 am

Title XVIII | 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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	03480	ONCOLOGY	0.000000		73.01
76.00	03160	CARDIOPULMONARY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/24/2017 9:10 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	4,067,272		4,067,272	0	4,067,272	30.00
31.00	03100	INTENSIVE CARE UNIT	1,697,936		1,697,936	0	1,697,936	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,200,043		4,200,043	0	4,200,043	50.00
53.00	05300	ANESTHESIOLOGY	105,728		105,728	0	105,728	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,772,445		2,772,445	0	2,772,445	54.00
60.00	06000	LABORATORY	2,099,341		2,099,341	0	2,099,341	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	715,018	0	715,018	0	715,018	65.00
66.00	06600	PHYSICAL THERAPY	1,435,162	0	1,435,162	0	1,435,162	66.00
67.00	06700	OCCUPATIONAL THERAPY	509,274	0	509,274	0	509,274	67.00
69.00	06900	ELECTROCARDIOLOGY	980,480		980,480	0	980,480	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	356,660		356,660	0	356,660	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,589,251		2,589,251	0	2,589,251	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,489,200		3,489,200	0	3,489,200	73.00
73.01	03480	ONCOLOGY	477,386		477,386	0	477,386	73.01
76.00	03160	CARDIOPULMONARY	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	302,470		302,470	0	302,470	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	3,525,897		3,525,897	0	3,525,897	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	786,888		786,888		786,888	92.00
200.00		Subtotal (see instructions)	30,110,451	0	30,110,451	0	30,110,451	200.00
201.00		Less Observation Beds	786,888		786,888		786,888	201.00
202.00		Total (see instructions)	29,323,563	0	29,323,563	0	29,323,563	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/24/2017 9:10 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	2,039,035		2,039,035			30.00
31.00	03100	INTENSIVE CARE UNIT	444,712		444,712			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,831,344	16,926,539	24,757,883	0.169645	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	355,658	502,853	858,511	0.123153	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	497,033	9,582,518	10,079,551	0.275056	0.000000	54.00
60.00	06000	LABORATORY	1,415,020	6,149,173	7,564,193	0.277537	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	512,157	720,283	1,232,440	0.580165	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	869,765	1,599,600	2,469,365	0.581187	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	383,757	341,697	725,454	0.702007	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	276,069	4,069,839	4,345,908	0.225610	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,487,805	869,368	2,357,173	0.151308	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,361,912	1,698,385	11,060,297	0.234103	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,075,184	7,921,042	10,996,226	0.317309	0.000000	73.00
73.01	03480	ONCOLOGY	0	1,847,026	1,847,026	0.258462	0.000000	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	606,731	606,731	0.498524	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	543,088	18,809,020	19,352,108	0.182197	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	16,371	1,202,271	1,218,642	0.645709	0.000000	92.00
200.00		Subtotal (see instructions)	29,108,910	72,846,345	101,955,255			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	29,108,910	72,846,345	101,955,255			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/24/2017 9:10 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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	03480	ONCOLOGY	0.000000		73.01
76.00	03160	CARDIOPULMONARY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/24/2017 9:10 am

Title XVIII | Hospital | Cost

		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	620,574	24,757,883	0.025066	4,213,858	105,625	50.00
53.00	05300	ANESTHESIOLOGY	12,146	858,511	0.014148	188,136	2,662	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	322,202	10,079,551	0.031966	207,673	6,638	54.00
60.00	06000	LABORATORY	132,789	7,564,193	0.017555	753,257	13,223	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	15,482	1,232,440	0.012562	228,354	2,869	65.00
66.00	06600	PHYSICAL THERAPY	158,270	2,469,365	0.064093	387,153	24,814	66.00
67.00	06700	OCCUPATIONAL THERAPY	27,911	725,454	0.038474	194,599	7,487	67.00
69.00	06900	ELECTROCARDIOLOGY	90,867	4,345,908	0.020909	160,567	3,357	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,624	2,357,173	0.004507	796,195	3,588	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	71,032	11,060,297	0.006422	5,329,722	34,227	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,138	10,996,226	0.005469	1,460,050	7,985	73.00
73.01	03480	ONCOLOGY	50,824	1,847,026	0.027517	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	54,069	606,731	0.089115	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	379,286	19,352,108	0.019599	6,336	124	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	93,457	1,218,642	0.076689	561	43	92.00
200.00		Total (lines 50-199)	2,099,671	99,471,508		13,926,461	212,642	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/24/2017 9:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/24/2017 9:10 am

Title XVIII | Hospital | Cost

		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	24,757,883	0.000000	0.000000	4,213,858	50.00
53.00	05300	ANESTHESIOLOGY	0	858,511	0.000000	0.000000	188,136	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,079,551	0.000000	0.000000	207,673	54.00
60.00	06000	LABORATORY	0	7,564,193	0.000000	0.000000	753,257	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,232,440	0.000000	0.000000	228,354	65.00
66.00	06600	PHYSICAL THERAPY	0	2,469,365	0.000000	0.000000	387,153	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	725,454	0.000000	0.000000	194,599	67.00
69.00	06900	ELECTROCARDIOLOGY	0	4,345,908	0.000000	0.000000	160,567	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,357,173	0.000000	0.000000	796,195	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,060,297	0.000000	0.000000	5,329,722	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,996,226	0.000000	0.000000	1,460,050	73.00
73.01	03480	ONCOLOGY	0	1,847,026	0.000000	0.000000	0	73.01
76.00	03160	CARDIOPULMONARY	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	606,731	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	19,352,108	0.000000	0.000000	6,336	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,218,642	0.000000	0.000000	561	92.00
200.00		Total (lines 50-199)	0	99,471,508			13,926,461	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/24/2017 9:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
73.01	03480	ONCOLOGY	0	0	0		73.01
76.00	03160	CARDIOPULMONARY	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/24/2017 9:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.169645	0	4,745,660	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.123153	0	111,778	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.275056	0	3,422,987	0	0	54.00
60.00	06000	LABORATORY	0.277537	0	2,014,769	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.580165	0	316,760	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.581187	0	644,229	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.702007	0	115,966	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.225610	0	1,800,603	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.151308	0	191,641	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234103	0	384,492	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317309	0	3,545,073	1,802	0	73.00
73.01	03480	ONCOLOGY	0.258462	0	999,865	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.498524	0	357,094	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.182197	0	6,324,465	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.645709	0	508,546	0	0	92.00
200.00		Subtotal (see instructions)		0	25,483,928	1,802	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	25,483,928	1,802	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/24/2017 9:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	805,077	0		50.00
53.00	05300	ANESTHESIOLOGY	13,766	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	941,513	0		54.00
60.00	06000	LABORATORY	559,173	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	183,773	0		65.00
66.00	06600	PHYSICAL THERAPY	374,418	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	81,409	0		67.00
69.00	06900	ELECTROCARDIOLOGY	406,234	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,997	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	90,011	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,124,884	572		73.00
73.01	03480	ONCOLOGY	258,427	0		73.01
76.00	03160	CARDIOPULMONARY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	178,020	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	1,152,299	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	328,373	0		92.00
200.00		Subtotal (see instructions)	6,526,374	572		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	6,526,374	572		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1311 | Component CCN: 15-Z311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/24/2017 9:10 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.169645	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.123153	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.275056	0	0	0	0	54.00
60.00	06000	LABORATORY	0.277537	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.580165	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.581187	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.702007	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.225610	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.151308	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234103	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317309	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0.258462	0	0	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.498524	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.182197	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.645709	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1311 | Component CCN: 15-Z311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V | Date/Time Prepared: 5/24/2017 9:10 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	03480	ONCOLOGY	0	0		73.01
76.00	03160	CARDIOPULMONARY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/24/2017 9:10 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.169645	0	182,599	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.123153	0	14,233	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.275056	0	67,801	0	0	54.00
60.00	06000	LABORATORY	0.277537	0	61,777	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.580165	0	990	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.581187	0	3,181	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.702007	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.225610	0	13,617	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.151308	0	7,095	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234103	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317309	0	43,643	0	0	73.00
73.01	03480	ONCOLOGY	0.258462	0	8,894	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.498524	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.182197	0	382,046	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.645709	0	2,048	0	0	92.00
200.00		Subtotal (see instructions)		0	787,924	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	787,924	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/24/2017 9:10 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	30,977	0		50.00
53.00	05300	ANESTHESIOLOGY	1,753	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,649	0		54.00
60.00	06000	LABORATORY	17,145	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	574	0		65.00
66.00	06600	PHYSICAL THERAPY	1,849	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
69.00	06900	ELECTROCARDIOLOGY	3,072	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,074	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,848	0		73.00
73.01	03480	ONCOLOGY	2,299	0		73.01
76.00	03160	CARDIOPULMONARY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	69,608	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,322	0		92.00
200.00		Subtotal (see instructions)	162,170	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	162,170	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/24/2017 9:10 am

Title XVIII | 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)	3,562	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,776	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)	2,106	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	674	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	112	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,411	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)	674	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	137.32	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)	4,067,272	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)	15,380	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)	806,966	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,260,306	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)	3,260,306	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)	1,174.46	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,657,163	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,657,163	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/24/2017 9:10 am

Title XVIII | 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,697,936	450	3,773.19	211	796,143	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)	3,367,514	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,820,820	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)	791,586	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)	791,586	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)	670	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,174.46	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	786,888	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/24/2017 9:10 am

Title XVIII | 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	483,061	4,067,272	0.118768	786,888	93,457	90.00
91.00	Nursing School cost	0	4,067,272	0.000000	786,888	0	91.00
92.00	Allied health cost	0	4,067,272	0.000000	786,888	0	92.00
93.00	All other Medical Education	0	4,067,272	0.000000	786,888	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/24/2017 9:10 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)	3,562	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,776	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)	2,106	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	674	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	112	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)	4	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		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)	4,067,272	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)	794,592	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,272,680	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)	3,272,680	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)	1,178.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,716	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	4,716	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/24/2017 9:10 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,697,936	450	3,773.19	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)	9,878	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	14,594	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)	670	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,178.92	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	789,876	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/24/2017 9:10 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	483,061	4,067,272	0.118768	789,876	93,812	90.00
91.00	Nursing School cost	0	4,067,272	0.000000	789,876	0	91.00
92.00	Allied health cost	0	4,067,272	0.000000	789,876	0	92.00
93.00	All other Medical Education	0	4,067,272	0.000000	789,876	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/24/2017 9:10 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,015,825		30.00
31.00	03100	INTENSIVE CARE UNIT		291,166		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.169645	4,213,858	714,860	50.00
53.00	05300	ANESTHESIOLOGY	0.123153	188,136	23,170	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.275056	207,673	57,122	54.00
60.00	06000	LABORATORY	0.277537	753,257	209,057	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.580165	228,354	132,483	65.00
66.00	06600	PHYSICAL THERAPY	0.581187	387,153	225,008	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.702007	194,599	136,610	67.00
69.00	06900	ELECTROCARDIOLOGY	0.225610	160,567	36,226	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.151308	796,195	120,471	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234103	5,329,722	1,247,704	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317309	1,460,050	463,287	73.00
73.01	03480	ONCOLOGY	0.258462	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.498524	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.182197	6,336	1,154	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.645709	561	362	92.00
200.00		Total (sum of lines 50-94 and 96-98)		13,926,461	3,367,514	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)		13,926,461		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1311 | Component CCN: 15-Z311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/24/2017 9:10 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.169645	2,650	450	50.00
53.00	05300	ANESTHESIOLOGY	0.123153	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.275056	39,843	10,959	54.00
60.00	06000	LABORATORY	0.277537	197,595	54,840	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.580165	116,113	67,365	65.00
66.00	06600	PHYSICAL THERAPY	0.581187	178,936	103,995	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.702007	84,869	59,579	67.00
69.00	06900	ELECTROCARDIOLOGY	0.225610	13,568	3,061	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.151308	6,815	1,031	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234103	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317309	396,626	125,853	73.00
73.01	03480	ONCOLOGY	0.258462	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.498524	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.182197	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.645709	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,037,015	427,133	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,037,015		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/24/2017 9:10 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		3,044		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.169645	25,251	4,284	50.00
53.00	05300	ANESTHESIOLOGY	0.123153	702	86	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.275056	4,462	1,227	54.00
60.00	06000	LABORATORY	0.277537	2,547	707	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.580165	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.581187	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.702007	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.225610	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.151308	687	104	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234103	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.317309	2,921	927	73.00
73.01	03480	ONCOLOGY	0.258462	0	0	73.01
76.00	03160	CARDIOPULMONARY	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.498524	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.182197	13,960	2,543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.645709	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		50,530	9,878	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)		50,530		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1311	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/24/2017 9:10 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,526,946	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	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)	6,526,946	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	6,592,215	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)	38,785	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	4,701,316	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)	1,852,114	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)	1,852,114	30.00
31.00	Primary payer payments	314	31.00
32.00	Subtotal (line 30 minus line 31)	1,851,800	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)	735,525	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	478,091	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	687,127	36.00
37.00	Subtotal (see instructions)	2,329,891	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,329,891	40.00
40.01	Sequestration adjustment (see instructions)	46,598	40.01
41.00	Interim payments	2,517,123	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-233,830	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	193,192	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I Date/Time Prepared: 5/24/2017 9:10 am

Title XVIII | Hospital | Cost

		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		5,503,139		2,517,123	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)		5,503,139		2,517,123	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		162,820		233,830	6.02
7.00	Total Medicare program liability (see instructions)		5,340,319		2,283,293	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: 15-1311 | Component CCN: 15-Z311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2017 9:10 am

Title XVIII | Swing Beds - SNF | Cost

		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		1,323,922		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	07/20/2016	103,800		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)		103,800		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)		1,427,722		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		239,894		0	6.02
7.00	Total Medicare program liability (see instructions)		1,187,828		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1311	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/24/2017 9:10 am
	Title XVIII	Hospital	Cost

		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	893	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,622	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	376	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	2,556	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	101,955,255	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,920,424	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	1	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1	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)	1	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1311 Component CCN: 15-Z311	Period: From 01/01/2016 To 12/31/2016	Worksheet E-2 Date/Time Prepared: 5/24/2017 9:10 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	799,502	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	431,404	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	674	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,230,906	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,230,906	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,230,906	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	18,837	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,212,069	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,212,069	0	19.00
19.01	Sequestration adjustment (see instructions)	24,241	0	19.01
20.00	Interim payments	1,427,722	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-239,894	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	14,641	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1311	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part V Date/Time Prepared: 5/24/2017 9:10 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,820,820	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	5,820,820	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,879,028	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	5,879,028	19.00
20.00	Deductibles (exclude professional component)	462,970	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	5,416,058	22.00
23.00	Coinsurance	322	23.00
24.00	Subtotal (line 22 minus line 23)	5,415,736	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	51,644	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	33,569	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	49,168	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,449,305	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	5,449,305	30.00
30.01	Sequestration adjustment (see instructions)	108,986	30.01
31.00	Interim payments	5,503,139	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	-162,820	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	203,599	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 5/24/2017 9:10 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	22,150,622	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,995,864	0	0	0	4.00
5.00	Other receivable	-347,784	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	658,239	0	0	0	7.00
8.00	Prepaid expenses	192,331	0	0	0	8.00
9.00	Other current assets	33,265	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)	27,682,537	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	2,116,905	0	0	0	17.00
18.00	Accumulated depreciation	-863,145	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	11,505,643	0	0	0	23.00
24.00	Accumulated depreciation	-8,735,982	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)	4,023,421	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	23,345,607	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	23,345,607	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	55,051,565	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,560,242	0	0	0	37.00
38.00	Salaries, wages, and fees payable	978,683	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	800,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,749,037	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,087,962	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	16,905,428	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	42,335	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	16,947,763	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	24,035,725	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	31,015,840				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)	31,015,840	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	55,051,565	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 5/24/2017 9:10 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		19,486,530		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,006,212				2.00
3.00	Total (sum of line 1 and line 2)		28,492,742		0		3.00
4.00	ADDITION TO UNRESTRICTED	2,807,970		0		0	4.00
5.00	ADDITION TO PERMANENTLY RESTRICTED	134,061		0		0	5.00
6.00	ROUNDING	1		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)		2,942,032		0		10.00
11.00	Subtotal (line 3 plus line 10)		31,434,774		0		11.00
12.00	REDUCTION IN TEMPORARILY RESTRICTED	418,934		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)		418,934		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		31,015,840		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	ADDITION TO UNRESTRICTED		0		4.00
5.00	ADDITION TO PERMANENTLY RESTRICTED		0		5.00
6.00	ROUNDING		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	REDUCTION IN TEMPORARILY RESTRICTED		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: 15-1311 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/24/2017 9:10 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,039,035		2,039,035	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,039,035		2,039,035	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	444,712		444,712	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)	444,712		444,712	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,483,747		2,483,747	17.00
18.00	Ancillary services	26,065,704	52,812,363	78,878,067	18.00
19.00	Outpatient services	559,459	20,011,291	20,570,750	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	0	2,540,276	2,540,276	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	29,108,910	75,363,930	104,472,840	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		33,341,288		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)		33,341,288		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-1311	Period: From 01/01/2016 To 12/31/2016	Worksheet G-3 Date/Time Prepared: 5/24/2017 9:10 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	104,472,840	1.00
2.00	Less contractual allowances and discounts on patients' accounts	63,504,947	2.00
3.00	Net patient revenues (line 1 minus line 2)	40,967,893	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	33,341,288	4.00
5.00	Net income from service to patients (line 3 minus line 4)	7,626,605	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	222,750	6.00
7.00	Income from investments	286,937	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	66,658	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	85,612	22.00
23.00	Governmental appropriations	26,492	23.00
24.00	MISCELLANEOUS INCOME	691,158	24.00
25.00	Total other income (sum of lines 6-24)	1,379,607	25.00
26.00	Total (line 5 plus line 25)	9,006,212	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)	9,006,212	29.00