(1) As Submitted

7. Contractor No.

(2) Settled without Audit

8. [N] Initial Report for this Provider CCN

11. Contractor's Vendor Code:

4. [O] If line 5, column 1 is 4: Enter

(3) Settled with Audit

9. [N] Final Report for this Provider CCN

number of times reopened = 0-9.

PART II - CERTIFICATION

(3)

(4) Reopened (5) Amended

Contractor

use only

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)

]Cost Report Status

Settled with Audit

6. Date Received:

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 MAJOR HOSPITAL (15-0097) 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.

> (Si aned) Officer or Administrator of Provider(s) Title

10. NPR Date:

number of times reopened = 0-9.

Title XVIII Title V HI T Cost Center Description Part A Part B Title XIX 1.00 2.00 3.00 4.00 5.00 PART III - SETTLEMENT SUMMARY 1.00 20, 648 -4, 315 -87, 167 Hospi tal 2.00 Subprovider - IPF 0 \cap Λ 2.00 0 3.00 Subprovider - IRF C 0 0 3.00 SUBPROVI DER I 4.00 4.00 Swing bed - SNF Swing bed - NF 5.00 0 0 C 0 5.00 6.00 0 6.00 HOME HEALTH AGENCY I 9.00 0 0 9.00 (RURAL HEALTH CLINIC I 0 10.00 0 0 10.00 11 00 FEDERALLY QUALIFIED HEALTH CENTER I 0 0 11 00 200.00 Total 20, 648 -4, 315 -87, 167 200. 00

Date

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. 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.

	42 CFR 412.105)? Enter in column 3, "Y" for yes or "N		anteu in ac	cordance wi				
	Which method is used to determine Medicaid days on li		or 25 belo	w? In colum	nn	3	N	23. 00
	1, enter 1 if date of admission, 2 if census days, or							
	method of identifying the days in this cost reporting				od			
	used in the prior cost reporting period? In column 2	2, enter "Y	' for yes o	or "N" for r	no.			
		In-State	In-State	Out-of	Out-of	Medi cai d	Other	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
		paid days	eligible	Medi cai d	Medi cai d		days	
			unpai d	pai d days	eligible			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
	If this provider is an IPPS hospital, enter the	378	1, 359	0	0	643	0	24. 00
	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.	_	_	_	_	_		
	If this provider is an IRF, enter the in-state	0	0	0	0	0		25. 00
	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.			I	l			

	AL AND HOSPITAL HEALTH CARE COMPI	EX IDENTIFICATION DA	TA	Provi der CC		eriod: com 01/01/2016	Worksheet S-2 Part I	
					To			pared 27 am
			Y/N	IME	Direct GME	I ME	Direct GME	
1.0/	E		1. 00	2. 00	3. 00	4. 00	5. 00	1
	Enter the amount of ACA §5503 aw used for cap relief and/or FTEs care or general surgery. (see in	that are nonprimary		0.00	0.00			61. (
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1. 00	2. 00	3. 00	4.00	
	Of the FTEs in line 61.05, speci specialty, if any, and the numbe for each new program. (see instrolumn 1, the program name, ente program code, enter in column 3, unweighted count and enter in co FTE unweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0. 00	0.00	61.
	Of the FTEs in line 61.05, speci program specialty, if any, and t residents for each expanded proginstructions) Enter in column 1, enter in column 2, the program c 3, the IME FTE unweighted count 4, direct GME FTE unweighted cou	he number of FTE ram. (see the program name, ode, enter in column and enter in column				0. 00	0. 00	61.
							1. 00	
	ACA Provisions Affecting the Hea							
2. 00	Enter the number of FTE resident your hospital received HRSA PCRE			I in this cost	reporting peri	od for which	0.00	62.
	Enter the number of FTE resident during in this cost reporting pe Teaching Hospitals that Claim Re	riod of HRSA THC prog	ıram. (s	<u>see instruction</u>		your hospital	0.00	62. (
3. 00	Has your facility trained reside "Y" for yes or "N" for no in col	nts in nonprovider se	ettings	during this co		eriod? Enter	N	63. (
	, , , , , , , , , , , , , , , ,	<u></u>	, , , , , , , ,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
					Nonprovi der Si te	Hospi tal	2))	
	Section 5504 of the ACA Base Yea	r FTF Dagidanta in No	anneaul e	Jan Cattinga T	1.00	2.00	3.00	1
4. 00	period that begins on or after J Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	uly 1, 2009 and befor yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	re June cy train n-primar all non l non-pr n column	30, 2010. ned residents ry care aprovider rimary care a 3 the ratio	0. 00			64. (
		Program Name	Pro	ogram Code	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1. 00		2. 00	Si te 3. 00	4. 00	5. 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				0.00			65. (

	EX IDENTIFICATION DATA	Provider CCN	: 15-0097	Peri od:		wof Form CMS- Worksheet S- Part I	
					2/31/2016	Date/Time Pr 5/25/2017 11	
					1. 00	2.00	_
33.00 f this is a Medicare certified of			ation date		1.00	2. 00	133. 0
in column 1 and termination date, 34.00 If this is an organ procurement or and termination date, if applicabl	rganization (OPO), enter th		column 1				134. 0
All Providers	C, TH COLUMN 2.						
40.00 Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	"N" for no in column 1. If	yes, and home of	ffice cost	S	N		140. (
1.00	2.00		UIS)		3. 00		
If this facility is part of a chai	in organization, enter on I	lines 141 throug		name and		of the	
home office and enter the home off 41.00 Name:	Contractor hame and co	ontractor number		tor's Nu	mber:		141. (
42.00 Street:	PO Box:						142. 0
43. 00 Ci ty:	State:		Zi p Cod	e:			143. 0
						1.00	
44.00 Are provider based physicians' cos	sts included in Worksheet A	4?				Υ	144. (
					1. 00	2. 00	
45.00 f costs for renal services are cl	aimed on Wkst. A, line 74,	are the costs	for		N	N	145. (
<pre>inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"</pre>	clude Medicare utilization						
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/c	gy changed from the previou n column 1. (See CMS Pub. 1			f	N		146.
						1. 00	
47.00 Was there a change in the statisti	cal basis? Enter "Y" for \	yes or "N" for r	10.			N N	147.
48.00 Was there a change in the order of	f allocation? Enter "Y" for	r yes or "N" for	no.			N	148. (
49.00 Was there a change to the simplifi	ed cost finding method? Er					N Till VIV	149. (
		Part A 1.00	Part B 2.00		itle V 3.00	Title XIX 4.00	+
Does this facility contain a provi		exemption from	the applic	ation of	the lowe	r of costs	
or charges? Enter "Y" for yes or ' 55.00 Hospi tal	N" for no for each compone	ent for Part A a	and Part B. N	(See 42	N S413	. 13) N	155. (
56. 00 Subprovi der - IPF		N	N		N	N	156. (
57. 00 Subprovi der - IRF		N	N		N	N	157. (
58. 00 SUBPROVI DER							158. (
59. 00 SNF		N	N		N	N	159. (
60. 00 HOME HEALTH AGENCY		N	N		N	N	160.
61. 00 CMHC			N		N	N	161. (
						1.00	
				erent CB	SAs?	N	165. (
Multicampus 65.00 s this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has one	e or more campus	ses in diff				
65.00 <mark>ls this hospital part of a Multica</mark>	Name	County	State Z	ip Code	CBSA	FTE/Campus	
55.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.		·				5. 00	00166.
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 66.00 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,	Name	County	State Z	ip Code	CBSA	5. 00	00 166.
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in	Name	County	State Z	ip Code	CBSA	5. 00	00 166. (
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 66.00 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)	Name 0	County 1.00	State Z 2.00	i p Code 3.00	CBSA	5. 00	00 166. (
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 66.00 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)	Name 0 T) incentive in the America	County 1.00 an Recovery and	State Z 2.00	i p Code 3.00	CBSA	5. 00 0. 0	
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 66.00 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) Health Information Technology (HIT 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10	Name 0 T) incentive in the America runder §1886(n)? Enter "Y 05 is "Y") and is a meaning	County 1.00 an Recovery and Y" for yes or "N gful user (line	State Z 2.00 Rei nvestme	ip Code 3.00	CBSA 4.00	5. 00 0. 0	167. (Q168. (
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 66.00 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)	Name 0 T) incentive in the America runder §1886(n)? Enter "Y D5 is "Y") and is a meaning HIT assets (see instruction	an Recovery and Y" for yes or "N gful user (line	Rei nvestme " for no. 167 is "Y"	ip Code 3.00	CBSA 4.00	5. 00 0. 0	167.

Health Financial Systems	MAJOR HOSP	TTAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provider CCN: 15-0097	Peri od:	Worksheet S-2	2
			From 01/01/2016 To 12/31/2016	Part Date/Time Pre	narod.
			10 12/31/2016	5/25/2017 11:	27 am
			Begi nni ng	Endi ng	
			1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR be period respectively (mm/dd/yyyy)	01/01/2016	12/31/2016	170. 00		
			1. 00	2. 00	
171.00 If line 167 is "Y", does this provi	der have any days for indi	viduals enrolled in	N	(171. 00
section 1876 Medicare cost plans re	ported on Wkst. S-3, Pt. I	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in colum		nter the number of section	on		
1876 Medicare days in column 2. (se	e instructions)				

HOSPI T	Financial Systems MAJOR HOS AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	_	CN: 15-0097	Peri od: From 01/01/2016 To 12/31/2016	u of Form CM Worksheet S Part II Date/Time P 5/25/2017 1	5-2 Prepared:	
		Descr	i pti on	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 (EXCEP	PT CHILDRENS H	HOSPI TALS)		1.00		
	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 of reporting period? If yes, see instructions.	N	23. 00				
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	eporting period?	N	24. 00			
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	rting period?	Plf yes, see	N	25. 00	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	e cost reporti	ng period? I	f yes, see	N	26. 00	
27. 00	Has the provider's capitalization policy changed during the copy.	ges, submit	N	27. 00			
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit en	N	28. 00				
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or through the provider have a funded depreciation account? If yes, see instruction	N	29. 00				
30. 00							
31. 00	instructions. Has debt been recalled before scheduled maturity without issinstructions.	s, see	N	31. 00			
32. 00	Purchased Services Have changes or new agreements occurred in patient care serv		ed through co	ontractual	N	32. 00	
33. 00	arrangements with suppliers of services? If yes, see instruction 1f line 32 is yes, were the requirements of Sec. 2135.2 applino, see instructions.		ng to competi	tive bidding? If	N	33. 00	
	Provi der-Based Physi ci ans						
34. 00	Are services furnished at the provider facility under an arr If yes, see instructions.	rangement with	n provi der-ba	sed physicians?	Υ	34.00	
35. 00			nts with the	provi der-based	N	35. 00	
	period in your sections and the section of the period in your section in			Y/N	Date		
				1. 00	2. 00		
	Home Office Costs						
	Were home office costs claimed on the cost report?			N		36. 00	
37. 00	If line 36 is yes, has a home office cost statement been proof of yes, see instructions.					37. 00	
	If line 36 is yes , was the fiscal year end of the home offi the provider? If yes, enter in column 2 the fiscal year end	of the home of	offi ce.			38. 00	
39. 00	see instructions.	·	,			39. 00	
40. 00	If line 36 is yes, did the provider render services to the linstructions.	home office?	If yes, see	N		40. 00	
		1.	00	2.	00		
	Cost Report Preparer Contact Information						
		KYLE		SMI TH		41. 00	
41. 00							
41. 00 42. 00	respecti vel y.	BLUE & CO				42. 00	

Heal th	n Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-	2552-10
H0SPI	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QU	JESTI ONNAI RE	Provider CCN:		Period: From 01/01/2016	Worksheet S-2 Part II	2
				Т	To 12/31/2016	Date/Time Pre 5/25/2017 11:	
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the tit	:le/position	SENI OR MANAGER				41. 00
	held by the cost report preparer in columns	1, 2, and 3,					
	respecti vel y.	ļ					
42.00	Enter the employer/company name of the cost	: report					42. 00
	preparer.	ļ					
43.00	Enter the telephone number and email addres	ss of the cost					43. 00
	report preparer in columns 1 and 2, respect	ti vel v.					1

In Lieu of Form CMS-2552-10

Period: Worksheet S-3

From 01/01/2016 Part I

To 12/31/2016 Date/Time Prepared: 5/25/2017 11: 27 am

						5/25/2017 11:	27 am
	<u> </u>					I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	38		0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and					_	
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
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		38	13, 908	0. 00	0	7. 00
7.00	beds) (see instructions)		30	13, 900	0.00	U	7.00
8. 00	INTENSIVE CARE UNIT	31. 00	8	2, 928	0. 00	0	8. 00
9. 00	CORONARY CARE UNIT	31.00	O	2, 720	0.00	U	9. 00
	1						
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			4, 00,			13. 00
14. 00	Total (see instructions)		46	16, 836	0. 00	0	14. 00
15. 00	CAH visits					0	15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF	41. 00	0	1		0	17. 00
18. 00	SUBPROVI DER	42. 00	0	0		0	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	101. 00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88. 00				0	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				ol	26. 25
27. 00	Total (sum of lines 14-26)		46				27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambul ance 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. 00	Total ancillary labor & delivery room		U				32. 00
JZ. U1	outpatient days (see instructions)						JZ. U1
33 00	LTCH non-covered days						33. 00
55.00	121011 11011 Cover cu days	1		1			55. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet S-3 | From 01/01/2016 | Part | From 01/01/201

				T	o 12/31/2016	Date/Time Pre	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time I	<u>5/25/2017_11::</u> Equi val ents	27 am
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
	I	6.00	7. 00	8. 00	9. 00	10. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	4, 263	352	9, 321			1. 00
	8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	1, 376	1, 808				2. 00
3. 00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	o	o				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	o	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7.00	Total Adults and Peds. (exclude observation	4, 263	352	9, 321			7. 00
	beds) (see instructions)		_				
8. 00	INTENSIVE CARE UNIT	508	0	1, 098			8. 00
9.00	CORONARY CARE UNIT						9.00
10. 00 11. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						10. 00 11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	4, 771	352	10, 419	0.00	669. 03	14. 00
15. 00	CAH visits	1, , , ,	0	0, 117	0.00	007.00	15. 00
16. 00	SUBPROVI DER - I PF		آ				16. 00
17. 00	SUBPROVI DER - I RF	O	О	0	0.00	0.00	17. 00
18.00	SUBPROVI DER		o	0	0.00	0.00	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	8, 051	442	11, 364	0. 00	3. 84	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00 24. 10	HOSPICE HOSPICE (non-distinct part)	0	0	0			24. 00 24. 10
25. 00	CMHC - CMHC	٩	٩	U			25. 00
26. 00	RURAL HEALTH CLINIC	0	0	0	0. 00	0.00	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	Ö	ő	0	0.00	0.00	26. 25
27. 00	Total (sum of lines 14-26)		٦	_	0.00	672. 87	27. 00
28. 00	Observation Bed Days		204	1, 121			28. 00
29. 00	Ambul ance Trips	O					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	220	355			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
22 00	outpatient days (see instructions)						22 00
33.00	LTCH non-covered days	0	ı			I	33. 00

| Peri od: | Worksheet S-3 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: | Part | P

				10) 12/31/2010	5/25/2017 11:2	
		Full Time	•	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	1, 192	72	2, 793	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			305	520		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						7. 00
	beds) (see instructions)						
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	1, 192	72	2, 793	14.00
15. 00	CAH visits						15.00
16.00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVI DER - I RF	0. 00	0	0	0	0	17.00
18. 00	SUBPROVI DER	0. 00	0		0	0	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	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC	0. 00					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	Ambul ance Tri ps						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						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared: | From CMS-2552-10 | Part II | Prepared: | From CMS-2552-10 | Part II | Prepared: | Part II | Part II | Prepared: | Part II |

					10	3 12/31/2010	Date/lime Pre 5/25/2017 11:	
		Worksheet A Line Number		Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							1
1.00	Total salaries (see	200. 00	44, 469, 081	0	44, 469, 081	1, 382, 442. 00	32. 17	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0.00	0. 00	2.00
3. 00	A Non-physician anesthetist Part		0	0	0	0.00	0.00	3. 00
4. 00	Physician-Part A -		404, 724	0	404, 724	2, 295. 00	176. 35	4. 00
4. 01	Administrative Physicians - Part A - Teaching		0	0	0	0.00		
5. 00	Physician and Non Physician-Part B		3, 295, 233		3, 295, 233			
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0. 00	0.00	6. 00
7. 00	Interns & residents (in an approved program)	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved programs)		0	О	О	0.00	0.00	7. 01
8. 00	Home office and/or related organization personnel		0	0	0	0.00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 4, 834, 425	0 194, 596	0 5, 029, 021	0. 00 128, 189. 00		
10.00	instructions) OTHER WAGES & RELATED COSTS		., 66 1, 126	171,070	3, 327, 32.	120, 107. 00	07120]
11. 00	Contract Labor: Direct Patient Care		116, 211	0	116, 211	2, 499. 00	46. 50	11. 00
12. 00	Contract labor: Top level management and other management and administrative		0	0	0	0.00	0.00	12.00
13. 00	services Contract Labor: Physician-Part		904, 376	0	904, 376	5, 399. 00	167. 51	13. 00
14. 00	A - Administrative Home office and/or related orgainzation salaries and		0	О	0	0.00	0.00	14. 00
14. 01	wage-related costs Home office salaries		0	0	0	0.00		14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00		1
16. 00	- Administrative Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16. 00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		11, 263, 162	0	11, 263, 162			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)		0	0	0			18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		1, 253, 408 0	0	1, 253, 408 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 00	B Physician Part A -		21, 568	0	21, 568			22. 00
22. 01	Administrative Physician Part A - Teaching		0	0	0			22. 01
23. 00	Physician Part B		453, 930	0	453, 930			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00 25. 00
25. 50 25. 51	approved program) Home office wage-related Related orgainzation		0	0	0			25. 50 25. 51
25. 52	wage-related Home office: Physician Part A		0) 	 			25. 51
02	- Administrative - wage-related		S					
25. 53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25. 53
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	.S 4. 00	533, 909	0	533, 909	11, 459. 00	46. 59	26. 00
	Administrative & General	5. 00	8, 778, 618	ł	· ·	·		27. 00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0097

Peri od: Worksheet S-3 From 01/01/2016 Part II Date/Time Prepared: 12/31/2016

5/25/2017 11:27 am Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number on of Salaries Sal ari es Related to Wage (col. 4 Reported col . 5) (from (col. 2 ± col. Salaries in Works<u>heet A-6)</u> col. 4 3) 1.00 2.00 6.00 3.00 4.00 5.00 28.00 Administrative & General under 729, 732 729, 732 4, 161. 00 175. 37 28.00 contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 Operation of Plant 30.00 7.00 1,024,732 0 1, 024, 732 40, 830. 00 25. 10 30.00 31.00 Laundry & Linen Service 8.00 31, 526 31, 526 2, 113. 00 14. 92 31.00 32.00 Housekeepi ng 9.00 898, 930 0 898, 930 58, 259. 00 15. 43 32.00 33.00 Housekeeping under contract 188, 399 188, 399 2, 116. 00 89. 04 33.00 (see instructions) 596, 125 11, 117. 00 34.00 10.00 -427, 675 168, 450 15. 15 34.00 Di etary 35.00 Di etary under contract (see 209, 614 209, 614 6, 247. 00 33. 55 35. 00 instructions) Cafeteri a 11.00 29, 615. 00 14. 44 36.00 427, 675 427, 675 36.00 0.00 Maintenance of Personnel 12.00 37.00 0.00 37.00 38.00 Nursing Administration 13.00 546,074 546, 074 14, 920. 00 36. 60 38.00 39.00 Central Services and Supply 14.00 253, 640 -253, 640 0.00 0.00 39.00 Pharmacy 40.00 15.00 1, 032, 069 1, 032, 069 25, 716. 00 40. 13 40.00 C Medical Records & Medical 41.00 16.00 813, 832 0 813, 832 35, 767. 00 22. 75 41.00 Records Library 42.00 Social Service 17.00 0 0 0.00 0.00 42.00 43.00 Other General Service 18.00 0 0 0.00 0.00 43.00 | Period: | Worksheet S-3 | From 01/01/2016 | Part III | To 12/31/2016 | Date/Time Prepared:

					11	0 12/31/2016	5/25/2017 11: 2	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		42, 301, 593	0	42, 301, 593	1, 385, 787. 00	30. 53	1.00
	instructions)							
2.00	Excluded area salaries (see		4, 834, 425	194, 596	5, 029, 021	128, 189. 00	39. 23	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		37, 467, 168	-194, 596	37, 272, 572	1, 257, 598. 00	29. 64	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		1, 020, 587	0	1, 020, 587	7, 898. 00	129. 22	4. 00
	costs (see inst.)							
5. 00	Subtotal wage-related costs		11, 284, 730	0	11, 284, 730	0. 00	30. 28	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		49, 772, 485					
7. 00	Total overhead cost (see		15, 637, 200	-448, 236	15, 188, 964	499, 986. 00	30. 38	7. 00
	instructions)							

Health Financial Systems	MAJOR HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0097	Peri od: Worksheet S-3
		From 01/01/2016 Part IV
		T- 10/01/001/ D-+-/T: D

	To 12/31/2016	Date/Time Prep 5/25/2017 11:	pared: 27 am
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	1, 787, 021	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	38, 470	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	7, 807, 832	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	42, 657	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	73, 251	
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	99, 205	13. 00
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	ı
15.00	'Workers' Compensation Insurance	156, 059	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		l
	TAXES		
17.00	FICA-Employers Portion Only	2, 978, 764	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unemployment Insurance	26, 592	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		l
22.00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	-17, 783	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12, 992, 068	24. 00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00
	· '	'	•

Health Financial Systems	MAJOR HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT CO		From 01/01/2016 To 12/31/2016	Worksheet S-3 Part V Date/Time Prepared:

		0 12/31/2010	5/25/2017 11:	
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospi tal	0	0	2. 00
3.00	Subprovi der - I PF			3. 00
4.00	Subprovi der - I RF	0	0	4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15. 00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Di al ysi s			17.00
18. 00	0ther	0	0	18. 00

MONE HEALTH ADERCY STATISTICAL DATA	Heal th	Financial Systems	MAJOR HO	SPI TAL		In Lie	eu of Form CMS-2	2552-10
Component CCR 19-7418 10 12/13/1016 13/15/2017 12/2 m 13/15/2017 13/2 m 13/2 m					CN: 15-0097	Peri od:		
Note Health Agency				Component				
Appendix County County Title V Title						Home Health		2/ am_
County								
County						1	00	
Note HEALTH AGENCY STATISTICAL DATA 1.00 2.00 3.00 4.00 5.00 1.00 2.00 1.00 2.00 4.158 2.80 0.00 0.00 0.00 2.00 2.00 3.03 0.00 0.00 2.00 2.00 3.03 0.00 0.00 2.00 2.00 3.00 0.00 2.00 3.00 0.00 2.00 3.00 0.00 2.00 3.00 0.00 2.00 3.00 0.00 0.00 3.00 0.00 0.00 3.00 0	0.00	County				_		0. 00
HOWE HEALTH AGENCY STATISTICAL BATA 1.00 Honduplicated Census Count (see Instructions) 0.00 303:00 0.00 0.00 0.00 0.00 2.00 0.0								
1.00 Index Heal th Alde Hours 0 0 333 00 0 0 0 0 0		HOME HEALTH AGENCY STATISTICAL DATA	1.00	2.00	3.00	4.00	5.00	
Number of Employees (Full Time Equivalent)		Home Health Aide Hours			1			1
Finter this number of hours in your normal work week Staff Contract Total	2.00	Unduplicated Census Count (see instructions)	0.00	303.00				2.00
HOME HEALTH ACENCY MIMBER OF EMPLOYEES 0 1.00 2.00 3.					I Valliber of Link	royces (ruir ii	me Equi vai ent)	
HOME HEALTH ACENCY MIMBER OF EMPLOYEES 0 1.00 2.00 3.								
NOME NEALTH AGENCY - NUMBER OF EMPLOYES			Enter the numb	er of hours in	Staff	Contract	Total	
HOME HEALTH ACENOY - NUMBER OF EMPLOYEES			your normal	work week				
HOME HEALTH ACENOY - NUMBER OF EMPLOYEES								
HOME HEALTH ACENOY - NUMBER OF EMPLOYEES								
Admin Instrator and Assistant Administrator(s) 40.00 3.15 0.00		HOME HEALTH ACENCY NUMBER OF EMPLOYEES)	1.00	2. 00	3. 00	
4.00 Director(s) and Assistant Director(s)	3. 00			40.00	3. 1	5 0.00	3. 15	3.00
Direct Nursing Service	4.00	Director(s) and Assistant Director(s)			0.0	0. 00	0.00	4. 00
Nursing Supervisor					1		l	1
9.00 Physical Therapy Supervisor 0.00 0.00 0.00 0.00 0.00 1.00 1.00 1.00 0.00 1.00 0.00 0.00 1.00 0.00 0.00 1.00 0.00 0.00 1.00 0.00 0.00 1.00 0.00 0.00 0.00 0.00 1.00 0.00 0.00 0.00 1.00 0.00 0.00 0.00 1.00 0.00 0.00 0.00 0.00 1.00 0.00					1		l	
10.00		1 3			1		l	
11.00 Cocupational Therapy Supervisor 0.00 0.00 0.00 0.00 0.00 11.00					1			
13.00 Speech Pathology Supervisor 0.00 0.00 0.00 0.00 13.00		1 1			1		•	
14.00 Medical Social Service 0.05 0.00 0.05 14.00					1		l	1
15.00 Medical Social Service Supervisor 0.00 0.00 0.00 0.00 15.00		, , , , , , , , , , , , , , , , , , , ,			1		1	
17.00 Home Heal th Ai de Supervi sor 0.00 0.00 0.00 0.00 0.00 17.00					1		l	
18. 00					l			
HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where you provided services during the cost reporting period. 26900 26900 20.00 20.00 26900 20.00 20.00 26900 20.00 20.00 26900 20.00 20.00 26900 20.00 20.00 26900 20.00 20.00 26900 20.00 20.00 26900 20.00 20.00 26900 20.00 20.00 26900 20.00 20.00 26900 20.00 20.00 26900 20.00 20.00 26900 20.00		•			l		l	
You provided services during the cost reporting period. 26900 20.00 20	18.00				0.0	0.00	0.00	10.00
Pep of tring period List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	19. 00					1		19. 00
26900 26900 20.0								
Full Episodes Without With Outliers LUPA Episodes PEP Only PEP On	20. 00	List those CBSA code(s) in column 1 serviced			26900			20. 00
Full Episodes Without With Outliers UPA Episodes PEP Only Fepisodes 1-4								
PPS ACTIVITY DATA 2.00 3.00 4.00 5.00		contains the first code).	Full Ep	oi sodes				
PPS ACTIVITY DATA				With Outliers	LUPA Epi sodes		7	
PPS ACTIVITY DATA				2.00	3.00			
22.00 Skilled Nursing Visit Charges 676, 212 135, 420 11, 100 8, 214 830, 946 22.00 23.00 Physical Therapy Visit S 2,009 255 8 35 2,307 23.00 24.00 Physical Therapy Visit Charges 423,899 53,805 422 7,385 485,511 24.00 25.00 Occupational Therapy Visit Charges 456 159 1 8 624 25.00 26.00 Occupational Therapy Visit Charges 101,688 35,457 223 1,784 139,152 26.00 27.00 Speech Pathology Visit Charges 18 6 0 0 24 27.00 28.00 Speech Pathology Visit Charges 4,086 1,362 0 0 5,448 28.00 29.00 Medical Social Service Visit Charges 31 2 0 0 5,448 28.00 30.00 Medical Social Service Visit Charges 9,548 616 0 0 0 10,164 30.00 31.00 Home Heal th Aide Visit Charges 99,456 46,704 224 1,456 147,840 32.00 35.00 Total Charges (sum of Lines 21, 23, 25, 27, 29, and 31) 0 0 0								
23.00 Physical Therapy Visits			1					
25. 00 Occupational Therapy Visits			1				l	
26.00 Occupational Therapy Visit Charges 101,688 35,457 223 1,784 139,152 26.00 27.00 Speech Pathology Visits 18 6 0 0 24 27.00 28.00 Speech Pathology Visit Charges 4,086 1,362 0 0 5,448 28.00 29.00 Medical Social Service Visits 31 2 0 0 33 29.00 30.00 Medical Social Service Visit Charges 9,548 616 0 0 10,164 30.00 31.00 Home Heal th Aide Visits 888 417 2 13 1,320 31.00 32.00 Home Heal th Aide Visit Charges 99,456 46,704 224 1,456 147,840 32.00 33.00 Total visits (sum of lines 21, 23, 25, 27, 29, and 31) 0 0 0 0 0 0 34.00 35.00 Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) 1,314,889 273,364 11,969 18,839 1,619,061 35.00 36.00 Total Number of Episodes (standard/non outlier) 22 3 359 36.00 37.00 Total Number of Outlier Episodes 28 1 29 37.00			1		1		l	
27. 00 Speech Pathology Visits 18 6 0 0 24 27. 00 28. 00 Speech Pathology Visit Charges 4,086 1,362 0 0 5,448 28. 00 29. 00 Medical Social Service Visits 31 2 0 0 33 29. 00 30. 00 Medical Social Service Visit Charges 9,548 616 0 0 10,164 30. 00 31. 00 Home Heal th Aide Visits 888 417 2 13 1,320 31. 00 32. 00 Home Heal th Aide Visit Charges 99,456 46,704 224 1,456 147,840 32. 00 33. 00 Total visits (sum of lines 21, 23, 25, 27, 29, and 31) 6,448 1,449 61 93 8,051 33. 00 35. 00 Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) 1,314,889 273,364 11,969 18,839 1,619,061 35. 00 36. 00 Total Number of Episodes (standard/non outlier) 334 22 3 359 36. 00 37. 00 Total Number of Outlier Episodes 28 1 29 37. 00								
29.00 Medical Social Service Visits		Speech Pathology Visits			1			
30.00 Medical Social Service Visit Charges 9,548 616 0 0 10,164 30.00 31.00 Home Health Aide Visits 888 417 2 13 1,320 31.00 32.00 Home Health Aide Visit Charges 99,456 46,704 224 1,456 147,840 32.00 Total visits (sum of lines 21, 23, 25, 27, 6,448 1,449 61 93 8,051 33.00 29, and 31) 0 Other Charges 0 0 0 0 0 0 34.00 35.00 Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) 36.00 Total Number of Episodes (standard/non outlier) 37.00 Total Number of Outlier Episodes 28 28 1 29 37.00			1	1, 362	•			
31.00 Home Health Aide Visits			1	616	1		l	1
33.00 Total visits (sum of lines 21, 23, 25, 27, 29, and 31) 34.00 Other Charges Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) 36.00 Total Number of Episodes (standard/non outlier) 37.00 Total Number of Outlier Episodes			888	417	1	2 13	1, 320	
29, and 31) 34. 00 Other Charges 0 0 0 0 0 0 34. 00 35. 00 Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) 36. 00 Total Number of Episodes (standard/non outlier) 37. 00 Total Number of Outlier Episodes 29, and 31) 0 0 0 0 0 0 0 34. 00 11, 969 18, 839 1, 619, 061 35. 00 22 3 3 359 36. 00 28 37. 00		, and the second			1		l	
34.00 Other Charges 0 0 0 0 0 0 34.00 35.00 Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) 36.00 Total Number of Episodes (standard/non outlier) 37.00 Total Number of Outlier Episodes 22, 24, 26, 28, 37.00	33.00		6, 448	1, 449	0	93	8,051	33.00
30, 32, and 34) 36.00 Total Number of Episodes (standard/non outlier) 37.00 Total Number of Outlier Episodes 28 29 30, 32, and 34) 20 31 359 36.00 21 29 37.00		Other Charges	0	-	•			1
36.00 Total Number of Episodes (standard/non outlier) 37.00 Total Number of Outlier Episodes 28 2 3 359 36.00 20 20 3 359 36.00 20 20 20 20 20 20 20 20 20 20 20 20 2	35. 00		1, 314, 889	273, 364	11, 96	9 18, 839	1, 619, 061	35. 00
outlier) 37.00 Total Number of Outlier Episodes 28 1 29 37.00	36. 00		334		2	2 3	359	36. 00
	27.00	outlier)				_		27.00
		•	0			o		

10SPI TAL	UNCOMPENSATED AND INDIGENT CARE DATA	Provi der Co	CN: 15-0097	Peri od: From 01/01/2016	Worksheet S-10	0			
				To 12/31/2016	Date/Time Prep 5/25/2017 11:				
					1. 00				
	ncompensated and indigent care cost computation								
	ost to charge ratio (Worksheet C, Part I line 202 colu	umn 3 divided by li	ne 202 columi	n 8)	0. 266680	1.0			
	edicaid (see instructions for each line) et revenue from Medicaid				3, 037, 435	2.0			
	Did you receive DSH or supplemental payments from Medicaid?								
	fline 3 is "yes", does line 2 include all DSH or supp		from Modicai	42	Y N	3.0			
4	f line 4 is "no", then enter DSH or supplemental payme	1 2	II olii wedi cart	u :	-1, 057, 021	5.0			
	edicaid charges	zirta irom medicard			42, 454, 351				
	edicaid cost (line 1 times line 6)				11, 321, 726	•			
	ifference between net revenue and costs for Medicaid p	orogram (line 7 min	us sum of lin	nes 2 and 5; if	9, 341, 312				
<	zero then enter zero)								
	nildren's Health Insurance Program (CHIP) (see instruc	ctions for each lin	e)						
- 1	et revenue from stand-alone CHIP				7, 066				
	tand-allone CHIP charges				30, 275	1			
	tand-alone CHIP cost (line 1 times line 10)	ao CIIID (lino 11 mi	nua lina O. i	if . zono thon	8, 074				
	ifference between net revenue and costs for stand-alor nter zero)	ie CHIP (TINE IT IIII	nus i i ne 9; i	ii < zero then	1, 008	12.			
	ther state or local government indigent care program (see instructions f	or each line)					
	et revenue from state or local indigent care program (0	13.			
4.00 Ch	narges for patients covered under state or local indig	gent care program (Not included	in lines 6 or	0	14.			
	0)								
	tate or local indigent care program cost (line 1 times				0				
	ifference between net revenue and costs for state or I	ocal indigent care	program (li	ne 15 minus line	0	16. (
	3; if < zero then enter zero) ncompensated care (see instructions for each line)								
	rivate grants, donations, or endowment income restrict	ted to funding char	itv care		0	17.0			
	overnment grants, appropriations or transfers for supp	9	,		0	18. 0			
9. 00 To	otal unreimbursed cost for Medicaid , CHIP and state a	and local indigent	care programs	s (sum of lines	9, 342, 320	19. (
8,	12 and 16)		1						
			Uni nsured	Insured	Total (col. 1				
			patients 1,00	pati ents 2, 00	+ col . 2) 3.00				
0. 00 Ch	narity care charges for the entire facility (see instr	ructions)	2, 827, 4		2, 827, 465	20.0			
	ost of patients approved for charity care (line 1 time		754, 0		754, 028				
	artial payment by patients approved for charity care	50 11110 20)	, , , ,	0 0	0	1			
	ost of charity care (line 21 minus line 22)		754, 0	28 0	754, 028				
<u> </u>	<u> </u>								
					1. 00				
	pes the amount in line 20 column 2 include charges for		ond a Length o	of stay limit	N	24. (
	mposed on patients covered by Medicaid or other indige f line 24 is "yes," charges for patient days beyond a		onram's Lang	th of stay limit	0	25. (
4									
7. 00 Me	on-Medicare and non-reimbursable Medicare had debt evr								
7. 00 Me 8. 00 No				e 28)					
27. 00 Me 28. 00 No 29. 00 Co	on-Medicare and non-reimbursable Medicare bad debt expost of non-Medicare and non-reimbursable Medicare bad ost of uncompensated care (line 23 column 3 plus line	debt expense (line		e 28)	1, 542, 221 2, 296, 249	29.			

	FINANCIAL SYSTEMS SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	MAJUK HUSI	Provider C	CN: 15 0007 I	Peri od:	Worksheet A	2332-10
RECLAS	SIFICATION AND ADJUSTMENTS OF IREAL BALANCE O	IF EXPENSES	Provider C		rom 01/01/2016		narod:
					10 12/31/2016	Date/Time Pre 5/25/2017 11:	
	Cost Center Description	Sal ari es	0ther		Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	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		2, 779, 903	2, 779, 903		2, 779, 903	1.00
3. 00 4. 00	00300 OTHER CAPITAL RELATED COSTS	533, 909	10, 081, 175	10 (15 00	0	10 (15 004	3. 00 4. 00
5. 01	OO4OO	333, 909	10, 061, 173	10, 615, 084	4 0 0 15, 000	10, 615, 084 15, 000	
5. 02	00550 DATA PROCESSING	1, 241, 960	2, 761, 048	4, 003, 008		4, 003, 008	
5.03	00590 PURCHASING, RECEIVING, AND STORES	271, 014	84, 132			355, 146	
5. 04	00570 ADMITTING	1, 138, 981	118, 958			1, 242, 939	
5. 05 5. 06	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00592 OTHER ADMINI STRATI VE AND GENERAL	459, 580 5, 667, 083	1, 015, 580 4, 436, 741			1, 475, 160 9, 729, 534	
7.00	00700 OPERATION OF PLANT	1, 024, 732	1, 391, 476			2, 416, 208	
8. 00	00800 LAUNDRY & LINEN SERVICE	31, 526	194, 855			226, 381	8. 00
9.00	00900 HOUSEKEEPI NG	898, 930	478, 032			1, 376, 962	1
10.00	01000 DI ETARY	596, 125	950, 310			436, 983	1
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON	0 546, 074	210, 914	1	1, 109, 452 3 0	1, 109, 452 756, 988	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	253, 640	386, 621			730, 766	14. 00
15. 00	01500 PHARMACY	1, 032, 069	7, 058, 862	1		8, 090, 931	
16.00	01600 MEDICAL RECORDS & LIBRARY	813, 832	365, 544	1, 179, 370	0	1, 179, 376	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	F 707 004	4 075 400		20.440	/ 00/ 7/0	00.00
30. 00 31. 00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	5, 797, 901 1, 137, 807	1, 075, 408 392, 495			6, 906, 769 1, 530, 302	
41. 00	04100 SUBPROVI DER – I RF	1, 137, 807	372, 473			1, 550, 502	1
42. 00	04200 SUBPROVI DER	o	0	1	0	0	
	ANCILLARY SERVICE COST CENTERS						
50.00	O5000 OPERATING ROOM O5200 DELIVERY ROOM & LABOR ROOM	3, 136, 018	1, 598, 220			5, 023, 726 0	
52. 00 53. 00	05300 ANESTHESI OLOGY	2, 643, 264	387, 324		-	3, 030, 588	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 294, 834	2, 827, 968			5, 122, 802	
56.00	05600 RADI OI SOTOPE	O	0	1	0	0	
56. 01	05601 ONCOLOGY	1, 154, 888	876, 278			2, 031, 166	
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	368, 399 355, 671	685, 610 408, 343			1, 054, 009 764, 014	
59. 00	05900 CARDI AC CATHETERI ZATI ON	333, 071	400, 343	704, 01-	0	704, 014	1
60.00	06000 LABORATORY	1, 830, 790	3, 027, 092	4, 857, 882	0	4, 857, 882	
60. 01	06001 BLOOD LABORATORY	0	0) (0	0	60. 01
65. 00 65. 01	06500 RESPI RATORY THERAPY 06501 SLEEP LAB	853, 195 443, 278	211, 591 203, 588			1, 064, 786 646, 866	
66. 00	06600 PHYSI CAL THERAPY	1, 597, 842	325, 313			1, 923, 155	
69. 00	06900 ELECTROCARDI OLOGY	536, 670	198, 354	735, 024	1 0	735, 024	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	134, 560	3, 897, 428	1		1, 947, 886	1
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0	1	2, 084, 102	2, 084, 102 0	1
73.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		/	<u> </u>	0	73.00
	08800 RURAL HEALTH CLINIC	0	C) (0	0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0) (0	0	
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	265, 400 2, 574, 684	131, 598 1, 742, 471	1		396, 998 4, 634, 468	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 374, 004	1, 742, 471	4, 317, 15	317, 313	4, 034, 400	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES	0	0		0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD 10000 L&R SERVICES-NOT APPRVD PRGM	0	0		0	0	97. 00 100. 00
	10000 TAR SERVICES-NOT APPROD PROM	804, 878	532, 016	1, 336, 89	1 0	1, 336, 894	
	SPECIAL PURPOSE COST CENTERS	0017070	002,010	1, 000, 07	., .	1, 000, 07,	
	11300 I NTEREST EXPENSE		O		0		113. 00
118.00	,	40, 439, 534	50, 835, 248	91, 274, 782	-374, 290	90, 900, 492	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0		n 0	0	190. 00
	19001 SHELBY COUNTY MEDICAL CENTER	o	Ö		o o		190. 01
	19002 SICK CHILD CARE	o	0		0	0	190. 02
	19003 PRI VATE DUTY	0	0		0		190. 03
	19004 ST. VINCENT'S STRESS 19005 MARKETING	0	0		374, 290	374, 290	190.04
	19006 MH LI GHTBOUND		0		0 374, 270		190.06
	19007 I -74 CAMPUS	123, 913	274, 511	398, 424	1 0	398, 424	
190.08	19008 SOUTHEAST OB	0	,= -) (0		190. 08
	19009 NTELLI PLEX DEVELOPMENT	2, 174	67, 281	69, 45!	0		190. 09 190. 10
	19010 MMG 19011 OTHER NON-REIMBURSEABLE CENTERS		0				190. 10
190. 12	19012 BARTLEY ORTHOPEDICS	0	0		o o	0	190. 12
190. 13	19013 SSA	0	0) (0	0	190. 13

Health Financial Systems	MAJOR HOS	PI TAL		In Li∈	eu of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der CO		Period: From 01/01/2016	Worksheet A	
				Γο 12/31/2016		
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
190. 14 19014 SPORTSWORKS	0	0	(0	0	190. 14
190. 15 19015 SHELBY PEDS	0	0	(0	0	190. 15
190. 16 19016 RENOVO	274, 385	1, 094, 835	1, 369, 220	0	1, 369, 220	190. 16
190. 17 19017 I MA	0	0	(0	0	190. 17
190. 18 19018 MD SOLUTIONS	414, 583	490, 495	905, 078	3 0	905, 078	190. 18
190. 19 19019 MHCD	0	1, 441, 627	1, 441, 62	7 0	1, 441, 627	190. 19
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	(0	0	192. 00
192. 01 19201 HOSPI TALI ST	2, 504, 424	448, 575	2, 952, 999	9 0	2, 952, 999	192. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	710, 068	191, 188	901, 256	6 0	901, 256	194. 00
200.00 TOTAL (SUM OF LINES 118-199)	44, 469, 081	54, 843, 760	99, 312, 84°	ı o	99, 312, 841	200. 00

Peri od: From 01/01/2016 To 12/31/2016 Date/Ti me Prepared: 5/25/2017 11: 27 am

Cost Center Description					5/25/2017 11:	27 am
In the color Service Cost Centres		Cost Center Description				
SEMPRIAL SERVICE COST CENTESS 1.00 CHORD OF PRIE COSTS IN DAY OF A FILTY 1.00 CHORD OF PRIE COSTS IN DAY OF A FILTY 1.00 CHORD OF A FILTY 1.						
0.100 0.100 0.00 0.100 0.00 0.100 0.00 0.100 0.		GENERAL SERVICE COST CENTERS	0.00	7.00		
4,00 00-000 IMPLOYUSE SERVEPT'S DEPARTMENT	1.00		-325, 554	2, 454, 349		1.00
0.100 COMMUNICATIONS	3.00			0		3. 00
1.00 1.00	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		10, 610, 327		4. 00
0.0390 NIRCHARN RO, RECEIVING, AMD STORES 0 335, 146 5.03 5.05 5.						
5.04 0.0570 ABUITTING			l .			
5.05 OGS90 CASHERING/ACCOUNTS RECEIVABLE						
5.06 00692 OTHER ARMINISTRATI VE AND GENERAL -1.311.480 8, 418,054 7.00 00700 OPERATI NO PLAY ELINEN SERVICE 0 0 226,381 8.00 00800 LANINGRY & LINEN SERVICE 0 1 226,381 8.00 10.00 01000 DIFTARY 1.00 00800 LANINGRY & LINEN SERVICE 0 1 228,149 110.00 10.00 DIFTARY 1.00 0.00 01000 DIFTARY 1.00 0.00 0.00 01000 DIFTARY 1.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0						
2,00 03700 OPERATION OF PLANT 0 2,416,208 7.00 9.00 03900 AURISTREPHIK 0 0.226,391 9.00 9.00 03900 AURISTREPHIK -198,801 1,376,940 9.00 9.00 1.376,940 9.00						
8.00 0 0800 (LAUNDRY & LINEN SERVICE 0 2 226, 381 9, 90 00 0900 (DISCREPTING 0 19, 00 0000 DISCREPTING 0 19, 00 1000 DISCREPTING 0 19, 00 11, 00 01 1000 DISCREPTING 0 19, 00 11, 00 01 1000 DISCREPTING 0 19, 00 11, 00 01 1000 (LERITRIA CHERRY 1 10, 00 1100 (LERITRIA SERVICES & SUPPLY 1 10, 00 1100 (LERITRIA SERVICES & SUPPLY 1 10, 00 1100 (LERITRIA SERVICES & SUPPLY 1 1, 10, 00 1100 (LERITRIA SERVICES & SUPPLY 1 1, 10, 00 1100 (LERITRIA SERVICES & SUPPLY 1 1, 172, 085 (LERITRIA SERVICES & SUPPLY 1 1, 172, 183 (LERITRIA SERVICES &			-1, 311, 400			
9. 00 09000 MUSISKEEP IN 6			0			
10.00 10000 DELTARY 1-99, 934 239, 149 110.00 113.00			-			
11.00 0 1100 (CAFETERIA -648, 078 461, 374 11.00		1				
14.00 01400 PENTAIN SERVICES & SUPPLY 0 1.93, 734 7, 897, 197 15.00 10100 PENTAIN SERVICES & SUPPLY -7, 291 1, 172, 085 10.00 10.00 PENTAIN SERVICE COST CENTERS -7, 291 1, 172, 085 30.00 303000 ADULT IS & PEDIATRIN SERVICE COST CENTERS -1, 694, 084 30.00 303000 ADULT IS & PEDIATRIN SERVICE COST CENTERS -1, 694, 084 30.00 303000 ADULT IS & PEDIATRIN SERVICE COST CENTERS -1, 694, 084 30.00 303000 ADULT IS & PEDIATRIN SERVICE COST CENTERS -1, 694, 084 30.00 303000 ADULT IS & PEDIATRIN SERVICE COST CENTERS -1, 694, 084 30.00 303000 ADULT IS & PEDIATRIN SERVICE COST CENTERS -1, 694, 084 30.00 303000 ADULT IS & PEDIATRIN SERVICE COST CENTERS -1, 694, 084 30.00 303000 OFERAT ING ROOM -1, 694, 084 30.00 303000 OFERAT ING ROOM -1, 694, 084 30.00 303000 OFERAT ING ROOM -1, 100, 694 30.00 303000 OFERAT ING ROOM -1, 100, 694 4, 917, 133 54.00 30.00 303000 ADULT SERVICE COST CENTERS -1, 100, 694 4, 917, 133 54.00 30.00 305000 ADULT SERVICE COST CENTERS -1, 100, 694 4, 917, 133 54.00 30.00 305000 ADULT SERVICE COST CENTERS -1, 100, 694 4, 917, 133 54.00 30.0		1				
15.00 01500 PHARMACY						
16. 00	14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		14. 00
INPATI ENT ROUTINE SERVICE COST CENTERS 30,00 330,00 330,00 30300 AULTS & PEDIA IRICS -212,685 6,694,084 33,00 31,00 310,00 1NTENSIVE CARE UNIT -41,170 1,489,132 31,00 41,00 414,00 41						
30.00	16. 00		-7, 291	1, 172, 085		16. 00
31.00 03100 INTENSIVE CARE_UNIT			T			4
11.00			1			
42. 00 04200 SUBPROVIDER 0 0 0 0 0 0 0 0 0						
ANCILLARY SERVICE COST CENTERS 50.00 50.00 50.00 50.00 50.00 65.		1				
50.00 OSDOO OPERATING ROOM	42.00			U		42.00
S2.00 05200 DELLYERY ROOM & LABOR ROOM 0 52.00	50 00		-712 990	4 310 736		50.00
53.00 05300 ANISTHESI OLOGY			1			
54.00 05400 RADIO LOCY-DIAGNOSTIC -1, 105, 649 4, 017, 153 55, 00 56.00 05600			_			
56.00 05600 RADIO I SOTOPE 0 0 0 55.00						
55.0 05601 05601 05601 05700 CT SCAN -179, 149 49 874, 860 55.0 05800 05800 05800 05800 05800 05900 05000	56. 00		1			
SB. 00 OBBOO MAGNETI C RESONANCE I MAGING (MRI) -91, 875 672, 139 0 59, 00 69, 00 60	56. 01	05601 ONCOLOGY	-218, 353	1, 812, 813		56. 01
59.00 05900 CARDIAC CATHETERI ZATION 0 0 0 0 0 0 0 0 0	57.00	05700 CT SCAN	-179, 149	874, 860		57.00
60.0 06000 06000 16000 16100 161800 1610	58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	-91, 875	672, 139		58. 00
60.01 06001 BLOOD LABORATORY 0			0	0		
65. 00 66500 RESPI RATORY THERAPY			-325, 543	4, 532, 339		
65.01 06501 SLEEP LAB		1	0	0		
66. 00 06600 PHYSICAL THERAPY -80, 491 1, 842, 664 69. 00 69. 00 06900 ELECTROCARDIOLOGY -130, 959 6004, 065 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT -200, 955 1, 746, 931 71. 00 72. 00 07200 INPL. DEV. CHARGED TO PATIENT 0 2, 084, 102 72. 00 73. 00 7300 DRUGS CHARGED TO PATIENT 0 0 0 88. 00 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 00 90. 00 09000 CLINIC -335, 566 61, 432 99. 00 91. 00 09100 EMERGENCY -960, 438 3, 674, 030 91. 00 92. 00 09200 085ERVATION BEDS (MON-DISTINCT PART) 92. 00 97. 00 09700 DURABLE MEDI CAL EQUIP-SOLD 0 0 97. 00 97. 00 09700 DURABLE MEDI CAL EQUIP-SOLD 0 0 97. 00 100. 00 10000 IAR SERVICES OOST CENTERS 97. 00 113. 00 113.00 INTEREST EXPENSES 0 0 0 113. 00 11300 INTEREST EXPENSE 0 0 0 114. 00 19000 GHEREST EXPENSE 0 0 0 115. 00 19000 GHEREST EXPENSE 0 0 0 110. 00 19000 18000 18000 18000 18000 18000 190. 01 19000 18000 18000 18000 18000 18000 190. 02 19000 18000 18000 18000 18000 18000 18000 190. 02 19000 18000 18000 18000 18000 18000 18000 190. 03 19000 18000 18000 18000 18000 18000 18000 18000 190. 04 19000 18000 18000 18000 18000 18000 18000 18000 190. 05 19000 18000 18000 18000 18000 18000 18000 190. 06 19000 18000 18000 18000 18000 19000 190. 07 19000 18000 18000 18000 18000 19000 190. 08 19000 18000 18000 18000 18000 19000 190. 09 19000 18000 18000 18000 19000 190. 00 19000 18000 18000 18000 18000 19000 190. 01 19000 18000 18000 18000						
69. 00 06900 ELECTROCARDI OLOGY -130, 959 604, 065 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS -200, 955 1, 746, 931 72. 00 73. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0						1
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS -200, 955 1, 746, 931 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 2, 084, 102 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0		1 1				
72. 00 07200 MPL DEV. CHARGED TO PATIENT 0 2,084,102 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73. 00 0000 000000						
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 OUTPATIENT SERVICE COST CENTERS 88. 00 OBSOOR RURAL HEALTH CLINIC O O O 89. 00 OBSOOR RURAL HEALTH CLINIC O O O 89. 00 OBSOOR RURAL HEALTH CLINIC O O O 89. 00 OBSOOR RURAL HEALTH CLINIC O O O 89. 00 OBSOOR RURAL HEALTH CLINIC O O O 89. 00 OBSOOR RURAL HEALTH CLINIC O O O 91. 00 OPOOD CLINIC OFFICE ALLY QUALIFIED HEALTH CENTER O O O 91. 00 OPOOD CLINIC OFFICE ALLY QUALIFIED HEALTH CENTER O O O 91. 00 OPOOD DEMERGENCY OPOOD OPOOD OBSERVATION BEDS (NON-DISTINCT PART) OPOOD OPOOD OBSERVATION BEDS (NON-DISTINCT PART) OPOOD OPOOD OBSERVATION BEDS (NON-DISTINCT PART) OPOOD OPOOD		1	1			1
OUTPATI ENT SERVICE COST CENTERS 88. 00 08900 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 0 0			1			
88. 00	73.00		0	U U		73.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	88. 00		0	0		88.00
91. 00 09100 EMERGENCY -960, 438 3, 674, 030 91. 00 92.00 0BSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 07.00		1	1			
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REI MBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVI CES O O O 100. 00 100000 I&R SERVI CES O O O 101. 00 O10000 I&R SERVI CES O O O 101. 00 O10000 I&R SERVI CES O O O 101. 00 O10000 I&R SERVI CES O O O 101. 00 O10000 I&R SERVI CES O O O 101. 00 SPECI AL PURPOSE COST CENTERS O O 113. 00 O11300 INTEREST EXPENSE O O O 113. 00 O11300 INTEREST EXPENSE O O O 115. 00 SUBTOTALS (SUM OF LINES 1-117) -9, 830, 825 81, 069, 667 119. 00 O19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN O O 190. 01 19001 SHELBY COUNTY MEDI CAL CENTER O O 190. 02 19002 SICK CHI LD CARE O O 190. 03 19003 PRI VATE DUTY O O 190. 04 19004 ST. VI NCENT'S STRESS O O 190. 05 19005 MARKETI NG O 374, 290 190. 06 19006 MARKETI NG O O 190. 07 19007 I -74 CAMPUS O O 190. 08 19008 SOUTHEAST OB O O 190. 09 190. 00 190. 01 19010 IMIG O O 190. 01 19010 IMIG O O 190. 02 190. 03 190. 04 19004 ST. VI NCENT'S STRESS O O O 190. 05 19005 MARKETI NG O O 190. 06 19006 MARKETI NG O O 190. 07 19007 I -74 CAMPUS O O 190. 08 19008 SOUTHEAST OB O O 190. 09 190. 09 190. 09 190. 01 19010 IMIG O O 190. 01 19010 IMIG O O 190. 01 19010 IMIG O O 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 02 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 01 190. 02 190. 01 190. 03 190. 02 190. 04 190. 04 190. 05 190. 05 190. 05 190		1	-335, 566	61, 432		
OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			-960, 438	3, 674, 030		91. 00
95. 00	92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
97. 00 100. 00 100. 00 100. 00 101. 00						4
100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM 0 0 100. 00 101. 00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 100.01 100.			0	0		
101. 00 10100 HOME HEALTH AGENCY -1, 272 1, 335, 622 101. 00			0	0		
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117) -9,830,825 81,069,667 118.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	4 005 (00		
113. 00	101.0		-1,272	1, 335, 622		1101.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) -9, 830, 825 81, 069, 667 118. 00	113 ∩		1	0		113 00
NONRE MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 01 19001 SHELBY COUNTY MEDI CAL CENTER 0 0 0 0 190. 01 190. 02 19002 SI CK CHI LD CARE 0 0 0 0 190. 02 190. 03 19003 PRI VATE DUTY 0 0 0 190. 03 19004 ST. VI NCENT'S STRESS 0 0 190. 04 19004 ST. VI NCENT'S STRESS 0 0 190. 04 19005 MARKETI NG 0 374, 290 190. 05 19005 MARKETI NG 0 374, 290 190. 06 190. 06 19006 MH LI GHTBOUND 0 0 190. 07 19007 1-74 CAMPUS 0 398, 424 190. 07 190. 07 19007 1-74 CAMPUS 0 398, 424 190. 07 190. 08 1908 SOUTHEAST 0B 0 0 0 190. 08 190. 09 19009 I NTELLI PLEX DEVELOPMENT 0 69, 455 190. 09 190. 10 19010 MMG 0 0 190. 10			-9 830 825			
190. 00 190. 01 1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 01 190. 01 190. 02 190. 02 190. 02 190. 03 190. 03 190. 04 190. 05 190. 05 190. 06 190. 06 190. 06 190. 06 190. 07 190. 07 190. 07 190. 08 190. 08 190. 08 190. 09 190. 08 190. 09 190. 09 190. 08 190. 09 190. 08 190. 09 190. 08 190. 09 190. 08 190. 09	110.0		7,030,023	01,007,007		1110.00
190. 01 19001 19001 19001 19002 19002 19002 19002 19002 19003 19003 19003 19003 19003 19005 19005 19006 19006 19006 19006 19006 19006 19006 19007 1900	190. 0		0	0		190.00
190. 02 19002 SICK CHILD CARE				0		
190. 04 19004 ST. VINCENT'S STRESS 0 0 0 190. 04 190. 05 19005 MARKETI NG 0 374, 290 190. 05 190. 06 190. 06 190. 07 19007 I -74 CAMPUS 0 398, 42 190. 08 190. 08 190. 08 SOUTHEAST OB 0 0 190. 09 190. 09 1 NTELLI PLEX DEVELOPMENT 0 69, 455 190. 10 190. 10			0	O		
190. 05 19005 MARKETI NG	190. 0	3 19003 PRI VATE DUTY	0	0		190. 03
190. 06 19006 MH LI GHTBOUND 0 0 190. 06 190. 07 19007 1-74 CAMPUS 0 398, 424 190. 08 190. 08 19008 SOUTHEAST 0B 0 0 0 190. 09 19009 I NTELLI PLEX DEVELOPMENT 0 69, 455 190. 09 190. 10 19010 MMG 0 0 0 190. 10	190.0	4 19004 ST. VINCENT'S STRESS	0	O		190. 04
190. 07 19007 1-74 CAMPUS 0 398, 424 190. 08 19008 SOUTHEAST OB 0 0 1900. 09 19009 I NTELLI PLEX DEVELOPMENT 0 69, 455 190. 10 19010 MMG 0 0 190. 10	190. 0	5 19005 MARKETI NG	0	374, 290		190. 05
190. 08 19008 SOUTHEAST OB			0	0		
190. 09 19009 NTELLI PLEX DEVELOPMENT 0 69, 455 190. 10 19010 MMG 0 0 190. 10		1	0	398, 424		
190. 10 19010 MMG 0 190. 10		1	0	0		
			0	69, 455		
			0	0		
		1 19011 OTHER NON-REIMBURSEABLE CENTERS	0	0		190. 11
190. 12 19012 BARTLEY ORTHOPEDICS 0 0 190. 12 190. 13 19013 SSA 0 190. 13		1 1	0	0		
190. 13 19013 SSA				0		
190. 14 19014 SPORTSWORKS 0 0 190. 14 190. 15 19015 SHELBY PEDS 0 0 190. 15				U		1
170.15	19∩ 1	DITANTOLOHERBY REDO	(1	()		

Health Financial Systems MAJOR HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-0097
From 01/01/2016
To 12/31/2016 Date/Time Prepared:

			5/25/2017 11: 27 am
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For Allocation	
	6. 00	7. 00	
190. 16 19016 RENOVO	0	1, 369, 220	190. 16
190. 17 19017 I MA	0	0	190. 17
190. 18 19018 MD SOLUTIONS	0	905, 078	190. 18
190. 19 19019 MHCD	-38, 525	1, 403, 102	190. 19
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	192. 00
192. 01 19201 HOSPI TALI ST	-18, 349	2, 934, 650	192. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	-4, 580	896, 676	194. 00
200.00 TOTAL (SUM OF LINES 118-199)	-9, 892, 279	89, 420, 562	200.00

Health Financial Systems MAJOR HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-0097 Period: From 01/01/2016 To 12/31/2016 Date/Time Prepared:

						lo 12/31/2016	6 Date/lime Pro 5/25/2017 11	epared: ·27 am
		Increases					7 07 207 2017 111	
	Cost Center	Li ne #	Sal ary	Other				
	2. 00	3.00	4. 00	5.00				
	A - CAFETERIA							
1.00	CAFETERI A	11.00	427, 675	68 <u>1, 7</u> 77				1.00
	0		427, 675	681, 777				
	B - COMMUNICATIONS							
1.00	COMMUNI CATI ONS	501	1 <u>5, 0</u> 00	0				1.00
	0		15, 000	0				
	C - CS&R OTHER							
1.00	ADULTS & PEDIATRICS	30.00	13, 255	20, 205				1.00
2.00	OPERATING ROOM	50.00	114, 681	174, 807				2. 00
3.00	EMERGENCY	<u>91.</u> 00	12 <u>5, 7</u> 04	19 <u>1, 6</u> 09				3. 00
	0		253, 640	386, 621				_
	D - MARKETING							
1.00	MARKETING	1 <u>90.</u> 05	19 <u>4, 5</u> 96	17 <u>9, 6</u> 94				1. 00
	0		194, 596	179, 694				
	E - IMPLANTABLE DEVICES RECLA							
1.00	IMPL. DEV. CHARGED TO	72. 00	66, 018	2, 018, 084				1. 00
	PATI ENT							
	0		66, 018	2, 018, 084				
500.00	Grand Total: Increases		956, 929	3, 266, 176				500.00

Health Financial Systems MAJOR HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-0097 Period: From 01/01/2016 To 12/31/2016 Date/Time Prepared:

					T	o 12/31/2016	5 Date/Time Pr 5/25/2017 11	epared: :27 am
		Decreases		<u>. </u>				
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.			
	6. 00	7. 00	8. 00	9. 00	10.00			
	A - CAFETERIA							
1.00	DI ETARY	10.00	427, 675	681, 777	0			1. 00
	0		427, 675	681, 777				
	B - COMMUNICATIONS							
1.00	ADMI TTI NG	5. 04	15, 000	0	0			1. 00
	0		15, 000	0				
	C - CS&R OTHER							
1.00	CENTRAL SERVICES & SUPPLY	14. 00	253, 640	386, 621	0			1. 00
2.00		0.00	0	0	0			2. 00
3.00		0.00	o	0	0			3. 00
		$ \top$	253, 640	386, 621	T 7			
	D - MARKETING							
1.00	OTHER ADMINISTRATIVE AND	5. 06	194, 596	179, 694	0			1. 00
	GENERAL							
	0		194, 596	179, 694				
	E - IMPLANTABLE DEVICES RECLA	SS						
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	66, 018	2, 018, 084	0			1. 00
	PATI ENTS							
	0		66, 018	2, 018, 084				
500.00	Grand Total: Decreases		956, 929	3, 266, 176				500.00

					o 12/31/2016	Date/Time Prep 5/25/2017 11:	pared:
				Acqui si ti ons		3/23/2017 11.	Z / GIII
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	1, 978, 356	0	C	0	0	1. 00
2.00	Land Improvements	6, 032, 222	77, 030		77, 030		2. 00
3.00	Buildings and Fixtures	86, 646, 132	48, 976, 493		48, 976, 493		3. 00
4.00	Building Improvements	3, 737, 952	3, 069, 830	C	3, 069, 830		4. 00
5.00	Fixed Equipment	868, 356	68, 547	C	68, 547	·	5. 00
6.00	Movable Equipment	31, 125, 982	5, 355, 513	C	5, 355, 513	1, 492, 332	6. 00
7.00	HIT designated Assets	0	0	C	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	130, 389, 000	57, 547, 413	C	57, 547, 413	1, 503, 152	8. 00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10. 00	Total (line 8 minus line 9)	130, 389, 000	57, 547, 413	C	57, 547, 413	1, 503, 152	10. 00
		Endi ng Bal ance	Fully				
			Depreciated				
		6.00	Assets 7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		7.00				
1. 00	Land	1, 978, 356	0				1. 00
2.00		1 1	0				2.00
3.00	Land Improvements	6, 109, 252 135, 622, 625	0				3.00
4. 00	Buildings and Fixtures	6, 807, 782	0				4.00
5.00	Building Improvements Fixed Equipment	926, 083	0				5. 00
6. 00	Movable Equipment	34, 989, 163	0				6. 00
7. 00	HIT designated Assets	34, 767, 103	0				7. 00
8. 00	Subtotal (sum of lines 1-7)	186, 433, 261	0				8.00
9. 00	Reconciling Items	100, 433, 201	0				9. 00
10.00	Total (line 8 minus line 9)	186, 433, 261	o				10.00
10.00	Tiotal (Title o milias Title)	100, 400, 201	Ч				10.00

Heal th	Financial Systems	MAJOR HOSPITAL			In Lieu of Form CMS-2552-10			
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der CC		Peri od:	Worksheet A-7		
					From 01/01/2016 To 12/31/2016		nared·	
					10 12/01/2010	5/25/2017 11:		
		SUMMARY OF CAPITAL						
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see			
					instructions)	instructions)		
		9. 00	10.00	11. 00	12. 00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUMI	N 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FIXT	2, 453, 113	0	323, 30	7 0	0	1.00	
3.00	Total (sum of lines 1-2)	2, 453, 113	0	323, 30	7 0	0	3.00	
		SUMMARY OF	- CAPITAL					
	Cost Center Description	Other	Total (1) (sum					
		Capi tal -Rel ate	` ' '					
		d Costs (see	through 14)					
		instructions)	g ,					
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2				
1.00	CAP REL COSTS-BLDG & FLXT	3, 483					1. 00	
3.00	Total (sum of lines 1-2)	3, 483	2, 779, 903				3. 00	
				•				

Health Financial Systems		MAJOR HO	MAJOR HOSPITAL			In Lieu of Form CMS-2552-10		
RECONCILIATION OF CAPITAL COSTS CENTERS			Provi der CCN: 15-0097		Peri od: Worksheet A- From 01/01/2016 Part III To 12/31/2016 Date/Time Pro 5/25/2017 11:		pared:	
		COME	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	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 & FLXT	186, 433, 261	0	186, 433, 26		0	1. 00	
3.00	Total (sum of lines 1-2)	186, 433, 261	0	186, 433, 26			3. 00	
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL				F CAPITAL				
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease		
			Capi tal -Relate					
			d Costs	through 7)				
		6. 00	7. 00	8. 00	9. 00	10.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS	_			_		
1.00	CAP REL COSTS-BLDG & FIXT	0	0		2, 450, 866		1. 00	
3.00	Total (sum of lines 1-2)	0	0		2, 450, 866	0	3. 00	
			SL	JMMARY OF CAPI	IAL			
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum		
			instructions)	instructions)	Capi tal -Rel ate			
					d Costs (see	through 14)		
					instructions)			
		11. 00	12. 00	13. 00	14. 00	15. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0		3, 483			
3.00	Total (sum of lines 1-2)) 0	0	l '	3, 483	2, 454, 349	3. 00	

				To	12/31/2016	Date/Time Prep 5/25/2017 11:2	oared: 27 am
				Expense Classification on		072072017	_ / G
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1. 00 B	2.00	3.00 CAP REL COSTS-BLDG & FLXT	4. 00	5. 00 11	1. 00
1.00	COSTS-BLDG & FLXT (chapter 2)	B	-323, 307	CAP REL COSTS-BEDG & TIXI	1.00	11	1.00
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2. 00	0	2. 00
3. 00	Investment income - other		0		0.00	0	3. 00
4 00	(chapter 2)		0		0.00		4.00
4. 00	Trade, quantity, and time discounts (chapter 8)		Ü		0.00	0	4. 00
5. 00	Refunds and rebates of		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
	suppliers (chapter 8)						
7. 00	Tel ephone services (pay stations excluded) (chapter	A	-2, 651	COMMUNI CATI ONS	5. 01	0	7. 00
	21)						
8. 00	Television and radio service		0		0. 00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9. 00
10. 00	Provi der-based physician	A-8-2	-3, 861, 865			О	10.00
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11. 00
	(chapter 23)					_	
12. 00	Related organization transactions (chapter 10)	A-8-1	0			0	12. 00
13.00	Laundry and linen service		0		0. 00	0	13.00
14.00	Cafeteria-employees and guests		-321, 872	CAFETERI A	11. 00 0. 00	0	14. 00 15. 00
15. 00	Rental of quarters to employee and others		U		0.00	0	15.00
16. 00	Sale of medical and surgical		0		0. 00	О	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than		0		0. 00	О	17. 00
18. 00	patients Sale of medical records and		0		0.00	0	18. 00
	abstracts						
19. 00	Nursing school (tuition, fees, books, etc.)		O		0.00	0	19. 00
20. 00	Vending machines		0		0. 00	О	20. 00
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	21. 00
	charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
	repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
	limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	COSTS-BLDG & FLXT Depreciation - CAP REL		0	*** Cost Center Deleted ***	2.00	0	27. 00
27.00	COSTS-MVBLE EQUIP		0	cost center bereted	2.00		27.00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	0. 00 67. 00	0	29. 00 30. 00
	therapy costs in excess of						
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		Ω	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)						
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	*** Cost Center Deleted ***	68. 00		31. 00
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00
33. 00	FOOD AND NUTRITION	В	-12, 823		10. 00	0	33. 00
34. 00	DIABETIC ED	В	-66, 960	NURSING ADMINISTRATION	13. 00	o	34. 00

| Period: | Worksheet A-8 | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 15-0097

Supplementary Supplementar					To	12/31/2016		
Cost Center Description Seals/Code (2) Amount Cost Center Line F Mast A-7 Heef						372372017 11.	27 4111	
34. 0 OSS_ MANAGEMENT B					To/From Which the Amount is	to be Adjusted		
34. 0 OSS_ MANAGEMENT B								
34. 0 OSS_ MANAGEMENT B								
34. DI CASE MANAGEMENT B		Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
SERIERAL 11 00 0 35.00 0 0 0 0 0 0 0 0 0	24 01	CACE MANACEMENT						24.01
100 100	34.01	CASE MANAGEMENT	В	-2, 800		5.06	U	34.01
INCOME			1				0	
ABORD ABORD ABORD ABORD A	36.00		B	-2, 247	CAP REL COSTS-BLDG & FIXT	1.00	9	36.00
Mile Committee Mile Committee Mile Committee Mile Mile Committee Mile M	37. 00		A	-479, 049	DATA PROCESSING	5. 02	0	37. 00
40.00 Mil ACCOUNTING CONTRACT A -1-45, 6-9/0THER ADMIN ISTRATIVE AND 5.06 0.40.00 0.41.00 0.42.00 0.42.00 0.42.00 0.42.00 0.42.00 0.42.00 0.42.00 0.42.00 0.44.00 0.42.00 0.42.00 0.44.00 0.42.00 0.42.00 0.42.00 0.42.00 0.44.00 0.42.00	38. 00		A	-7. 540	ADMI TTI NG	5. 04	0	38. 00
14.00 MI ADMINISTRATION CONTRACT A -436, 416 OTHER ADMINISTRATIVE AND 5.06 0 42.00	40. 00		1		OTHER ADMINISTRATIVE AND	5. 06	0	40. 00
LABOR ACCOUNTING VENDOR REBATES B -2.99 PS-0 INTER ADMINISTRATIVE AND 5.06 0.42.00	41. 00	MH ADMINISTRATION CONTRACT	A	-436, 416	1	5. 06	0	41. 00
SENERAL		LABOR			GENERAL		_	
MA COCUMITING VENIOR REBATES B	42.00	MH EDUCATION CLASS REVENUE	В	-14, 924		5. 06	O	42.00
45.00 MF OTHER REVENUES PURCHASE D IS COUNTS NOTHER REVENUES B -2, 879 OTHER ADMINISTRATIVE AND CENERAL B -4, 1000 OTHER ADMINISTRATIVE AND CENERAL MR OTHER REVENUES B -4, 1000 OTHER ADMINISTRATIVE AND S. 0.0 0 45.01 REAPPOINT MEM FEES MR ACCOUNT NO PENALTIES B -18, 076 OTHER ADMINISTRATIVE AND S. 0.0 0 45.02 MR SCELLARIOUS INFO PENALTIES B -18, 076 OTHER ADMINISTRATIVE AND S. 0.0 0 45.02 MR ACCOUNT NO PENALTIES B -18, 076 OTHER ADMINISTRATIVE AND S. 0.0 0 45.02 CENERAL CENERAL MR OTHER REVENUES RED OTHER B -2, 440 NURSING ADMINISTRATIVE AND S. 0.0 0 45.04 CENERAL MR OTHER REVENUES XEROX AND S7, 291 MEDICAL RECORDS & LIBRARY MR OTHER REVENUES BASY PHOTO B -240 ADULTS & PEDIATRICS MR OTHER REVENUES BASY PHOTO B -240 ADULTS & PEDIATRICS MR OTHER REVENUES BASY PHOTO MR CHARA MET & BEHAB CONTRACT A -28, 808 PHYSICAL THERAPY MR CAR MET & BEHAB CONTRACT LASOR MR OTHER REVENUES BASY PHOTO B -1, 2501 NTENSIVE CASE UNIT AND CONTRACT MR CHARA SUCS-SMX CONTRACT A -28, 808 PHYSICAL THERAPY MR CAR MET & BEHAB CONTRACT LASOR MR CHARA SON BEHAB CONTRACT A -31, 788 PLECTROCARDIOLOGY MR CHARA SON BHEELS A -31, 7804 MEDICAL SUPPLIES CHARGED TO MR MICHAEL SON BHEELS A -36, 804 MID IN STRATI VE AND CENERAL MR	44. 00	MH ACCOUNTING VENDOR REBATES	В	-29, 054	OTHER ADMINISTRATIVE AND	5. 06	0	44. 00
DISCOUNTS	45. 00	 MH OTHER REVENUES PURCHASE	В	-2.879		5. 06	0	45. 00
REAPPOINTMENT FEES B		DI SCOUNTS	_	•	GENERAL		_	
45. 02 MI OTHER REVENUES MI ACCURTING PENALTIES MI A	45. 01		В	-4, 100		5. 06	0	45. 01
45. 03	45. 02	MH OTHER REVENUES	В	-18, 076	OTHER ADMINISTRATIVE AND	5. 06	0	45. 02
AS 0.04 MH CL NUTR/DI AB ED OTHER B	45. 03	4	В	1, 775	F -	5. 06	0	45. 03
CAFETERIA R 6A.50. SM HARMACY VENDOR REBATES B -1. 678 PHARMACY 15. 00 0 45. 05 MH OTHER REVENUES XEROX AND COPYING 45. 07 MH COMM. OUTREACH CONTRACT LABOR 45. 08 MH OTHER REVENUES BABY PHOTO INCOME MH COUTREACH CONTRACT LABOR 45. 10 MH CENTRAL SUPPLY VENDOR REBATES 45. 11 ML CAR MGT & REHAB CONTRACT LABOR 45. 11 ML CAR MGT & REHAB CONTRACT LABOR 45. 11 ML CAR MGT & REHAB CONTRACT LABOR 45. 11 ML CAR MGT & REHAB CONTRACT LABOR 45. 12 ML CENTRAL SUPPLY VENDOR REBATES 45. 13 ML MED. SPEC. CNTR RENTAL INCOME 45. 14 MEALS ON WHEELS 4 A -186, 011 DIETARY 45. 15 IHHA/AHA DUES 4 A -334 ABMEDLOKAL SUPPLIES CHARGED TO PROMOTIONAL GIFTS 4 A -334 ABMEDLOKAL SUPPLITE AND MINISTRATIVE AND CINERAL 45. 19 PROMOTIONAL GIFTS 4 A -342 ONLIFER ADMINISTRATION 45. 20 PROMOTIONAL GIFTS 4 A -220 ONLIFER ADMINISTRATION 45. 20 PROMOTIONAL GI					GENERAL			
45.05 MH PHARMACY VENDOR REBATES B -1, 678 PHARMACY 15.00 0 45.05	45. 04		В	-2, 440	NURSING ADMINISTRATION	13.00	O	45. 04
COPYING 45.07 ML COMM. OUTREACH CONTRACT LABOR 45.08 ML OTHER REVENUES BABY PHOTO 1 NOOME 45.09 ML OUT OUTHER INCOME 45.10 ML OTHER INCOME 45.11 ML CAR MCT & REHAB CONTRACT 45.12 ML CAR MCT & REHAB CONTRACT 45.12 ML CENTRAL SUPPLY VENDOR 45.13 ML OTHER EXPENSE 45.13 ML MED. SPEC. CNTR RENTAL 45.14 ML OTHER INCOME 45.15 ML OTHER EXPENSE 4 A -138.6111 DIETARY 4 C. SON WHEELS 4 A -186.6111 DIETARY 4 C. SON WHEELS 4 A -186.6111 DIETARY 5 C. SON OTHER DMIN ISTRATIVE AND 5 C. SON		MH PHARMACY VENDOR REBATES						
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45. 08 MH OTHER REVENUES BABY PHOTO NOTHER REVENUES BABY PHOTO NOTHER REVENUES BABY PHOTO NOTHER REVENUES BABY PHOTO NOTHER STREET	45. 07	MH COMM. OUTREACH CONTRACT	A	-25, 808	ADULTS & PEDIATRICS	30. 00	0	45. 07
NCOME	45. 08		В	-240	ADULTS & PEDLATRICS	30.00	0	45. 08
45. 10 MM REHAB SVGS-SWK CONTRACT LABOR 45. 11 MM CAR MGT & REHAB CONTRACT LABOR 45. 12 MM CAR MGT & REHAB CONTRACT LABOR 45. 12 MM CAR MGT & REHAB CONTRACT LABOR 45. 12 MM CAR MGT & REHAB CONTRACT LABOR 45. 12 MM CAR MGT & REHAB CONTRACT LABOR 45. 12 MM CAR MGT & REHAB CONTRACT LABOR 45. 12 MM CAR MGT & REHAB CONTRACT 45. 12 MM CAR MGT & REHAB CONTRACT 45. 12 MM CAR MGT & REHAB CONTRACT 45. 13 MM MED. SPEC. CNTR RENTAL B B -378, 804 MEDICAL SUPPLIES CHARGED TO PATIENTS 45. 13 MM MED. SPEC. CNTR RENTAL B -188, 513 CLINIC 90. 00 45. 14 45. 15 INCOME 45. 14 MELS. ON WHEELS A A -186, 011 DI ETARY 10. 00 9 45. 14 45. 15 INHA/AHA DUES A A -55, 500 OTHER ADMINISTRATIVE AND GENERAL 45. 16 PROMOTIONAL GIFTS A -334 EMPLOYEE BENEFITS DEPARTMENT A. 00 45. 16 45. 17 RECENERAL 45. 19 PROMOTIONAL GIFTS A -426 NURSING ADMINISTRATIVE AND GENERAL 45. 19 PROMOTIONAL GIFTS A -22, 015 ADDULTS & PEDIA TRICS 30. 00 45. 20 45. 21 PROMOTIONAL GIFTS A -22, 015 ADDULTS & PEDIA TRICS 30. 00 45. 20 45. 21 PROMOTIONAL GIFTS A -224 RESPIRATORY THERAPY 65. 01 45. 23 45. 24 PROMOTIONAL GIFTS A -224 RESPIRATORY THERAPY 65. 01 45. 23 45. 25 PROMOTIONAL GIFTS A -224 RESPIRATORY THERAPY 65. 00 45. 24 45. 26 PROMOTIONAL GIFTS A -247 SLEEP LAB 65. 01 0 45. 25 45. 26 PROMOTIONAL GIFTS A -247 SLEEP LAB 65. 01 0 45. 26 45. 27 PROMOTIONAL GIFTS A -247 SLEEP LAB 66. 00 0 45. 24 45. 28 PROMOTIONAL GIFTS A -247 SLEEP LAB 66. 00 0 45. 24 45. 29 ROMOTIONAL GIFTS A -247 SLEEP LAB 66. 00 0 45. 24 45. 20 PROMOTIONAL GIFTS A -259 PHYSICAL THERAPY 66. 00 0 45. 26 45. 27 PROMOTIONAL GIFTS A -3. 600 THER ADMINISTRATIVE AND GENERAL 45. 30 ADVERTISING EXPENSE A -5. 715 PHYSICAL THERAPY 66. 00 0 45. 30 45. 31 45. 34 HAF EXPENSE A -390 JURISH ROADMINISTRATIVE AND GENERAL 45. 35 HAF EXPENSE A -390 JURISH ROADMINISTRATIVE AND GENERAL 45. 36 HAF EXPENSE A -390 JURISH ROADMINISTRATIVE AND GENERAL 45. 36 HAF EXPENSE A -390 JURISH ROADMINISTRATION 50. 00 45. 34 45. 38 HAF EXPENSE A -390 JURISH ROADMINISTRATION 50. 00 45. 34 45. 39 HAF EXPENSE A -390 JURISH ROADMINISTRATION		INCOME						
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45. 12	45. 11		A	-31, 788	ELECTROCARDI OLOGY	69. 00	9	45. 11
45. 13	45. 12	MH CENTRAL SUPPLY VENDOR	В	-37, 804		71. 00	0	45. 12
NCOME	45 13		B	-188 513		90.00	0	45 13
45. 15		I NCOME						
Seneral Sene							9	
45. 17 PROMOTI ONAL GIFTS	43. 13				GENERAL	3.00		45. 15
SENERAL GENERAL GENE					1		-	
45. 20 PROMOTI ONAL GIFTS	43. 17	TROMOTTOWNE GIT IS		·	GENERAL	3.00	Ĭ	43.17
45. 21 PROMOTI ONAL GIFTS			1		i i		-	
45. 23			1		i i		-	
45. 24 PROMOTI ONAL GIFTS A -324 RESPIRATORY THERAPY 65. 00 0 45. 24 45. 25 PROMOTI ONAL GIFTS A -241 SLEEP LAB 65. 01 0 45. 25 45. 26 PROMOTI ONAL GIFTS A -259 PHYSI CAL THERAPY 66. 00 0 45. 26 45. 27 PROMOTI ONAL GIFTS A -627 ELECTROCARDI OLOGY 69. 00 0 45. 26 45. 28 ADVERTI SI NG EXPENSE A -3,508 OTHER ADMINI STRATI VE AND GENERAL 5. 06 0 45. 28 45. 29 ADVERTI SI NG EXPENSE A -1,165 RADI OLOGY-DI AGNOSTI C 54. 00 0 45. 29 45. 31 COMMUNI TY OUTREACH A -5,715 PHYSI CAL THERAPY 66. 00 0 45. 30 45. 32 HAF EXPENSE A -644, 561 OTHER ADMINI STRATI VE AND GENERAL 5. 06 OTHER ADMINI STRATI VE AND GENERAL 45. 31 0 0 45. 31 45. 32 HAF EXPENSE A -192,056 PHARMACY 15. 00 0 45. 32 45. 37			1		i i		-	
45. 25 PROMOTI ONAL GIFTS A -241 SLEEP LAB 65. 01 0 45. 25 45. 26 PROMOTI ONAL GIFTS A -259 PHYSI CAL THERAPY 66. 00 0 45. 26 45. 27 PROMOTI ONAL GIFTS A -627 ELECTROCARDI OLOGY 69. 00 0 45. 27 45. 28 ADVERTI SI NG EXPENSE A -3,508 OTHER ADMI NI STRATI VE AND GENERAL 5. 06 0 45. 28 45. 29 ADVERTI SI NG EXPENSE A -1,165 RADI OLOGY-DI AGNOSTI C 54. 00 0 45. 29 45. 30 ADVERTI SI NG EXPENSE A -5,715 PHYSI CAL THERAPY 66. 00 0 45. 30 45. 31 COMMUNI TY OUTREACH A -644, 561 OTHER ADMI NI STRATI VE AND GENERAL 5. 06 0 45. 31 45. 32 HAF EXPENSE A -192, 056 PHARMACY 13. 00 0 45. 32 45. 34 HAF EXPENSE A -192, 056 PHARMACY 15. 00 0 45. 34 45. 37 HAF EXPENSE A -39, 920 INTENSI VE CARE UNI T 31. 00 0 45. 37 45. 38 HAF EXPENSE A -352, 990 OPERATI NG ROOM 50. 00 0 45. 39 45. 40 HAF EXPENSE A			1		i I			
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45. 28 ADVERTISING EXPENSE A -3,508 OTHER ADMINISTRATIVE AND GENERAL 5.06 0 45.28 GENERAL 45. 29 ADVERTISING EXPENSE A -1,165 RADI OLOGY-DI AGNOSTIC 54.00 0 45.29 45. 30 ADVERTISING EXPENSE A -5,715 PHYSI CAL THERAPY 66.00 0 45.30 45. 31 COMMUNI TY OUTREACH A -644,561 OTHER ADMINISTRATIVE AND GENERAL 5.06 0 45.31 45. 32 HAF EXPENSE A -39 NURSING ADMINISTRATION 13.00 0 45.32 45. 34 HAF EXPENSE A -192,056 PHARMACY 15.00 0 45.34 45. 35 HAF EXPENSE A -184,622 ADULTS & PEDIATRICS 30.00 0 0 45.35 45. 37 HAF EXPENSE A -39,920 INTENSIVE CARE UNIT 31.00 0 45.37 45. 38 HAF EXPENSE A -352,990 OPERATING ROOM 50.00 0 45.39 45. 40 HAF EXPENSE A -54,773 ANESTHESI OLOGY 53.00 0 45.39 45. 40 HAF EXPENSE A -213, 269 RADI OL			1		ı ı		-	
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45. 35 HAF EXPENSE A -184, 622 ADULTS & PEDI ATRI CS 30. 00 0 45. 35 45. 37 HAF EXPENSE A -39, 920 I NTENSI VE CARE UNI T 31. 00 0 45. 37 45. 38 HAF EXPENSE A -352, 990 OPERATI NG ROOM 50. 00 0 45. 38 45. 39 HAF EXPENSE A -54, 773 ANESTHESI OLOGY 53. 00 0 45. 39 45. 40 HAF EXPENSE A -213, 269 RADI OLOGY-DI AGNOSTI C 54. 00 0 45. 40					1		o	
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					0 12/01/2010	5/25/2017 11:	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is			
					·		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
45. 42	HAF EXPENSE	A	-178, 890	CT SCAN	57. 00	0	45. 42
45. 43	HAF EXPENSE	A	-91, 875	MAGNETIC RESONANCE IMAGING	58. 00	0	45. 43
				(MRI)			
45. 44	HAF EXPENSE	A	-325, 543	LABORATORY	60.00		45. 44
45. 45	HAF EXPENSE	A	-31, 749	RESPIRATORY THERAPY	65.00		45. 45
45. 46	HAF EXPENSE	A	-40, 002	SLEEP LAB	65. 01	0	45. 46
45. 47	HAF EXPENSE	A	-43, 971	PHYSI CAL THERAPY	66.00	0	45. 47
45. 48	HAF EXPENSE	A	-40, 634	ELECTROCARDI OLOGY	69. 00	0	45. 48
45. 49	HAF EXPENSE	A	-163, 151	MEDICAL SUPPLIES CHARGED TO	71.00	0	45. 49
				PATI ENTS			
45. 50	HAF EXPENSE	A	-2, 727	CLINIC	90.00	0	45. 50
45. 51	HAF EXPENSE	A	-584, 919	EMERGENCY	91.00	0	45. 51
45. 52	HAF EXPENSE	A	-1, 272	HOME HEALTH AGENCY	101.00	0	45. 52
45. 53	HAF EXPENSE	A	-38, 525	MHCD	190. 19	0	45. 53
45. 54	HAF EXPENSE	A	-18, 349	HOSPI TALI ST	192. 01	0	45. 54
45. 55	HAF EXPENSE	A	-4, 580	OTHER NONREIMBURSABLE COST	194. 00	0	45. 55
				CENTERS			
45. 56			0		0.00	0	45. 56
45. 57			0		0.00	0	45. 57
45. 58			0		0.00	0	45. 58
50.00	TOTAL (sum of lines 1 thru 49)		-9, 892, 279				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

- (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.

PROVI DER BASED PHYSI CI AN ADJUSTMENT

Provider CCN: 15-0097

Peri od: Worksheet A-8-2 From 01/01/2016 To 12/31/2016 Date/Time Prepared:

5/25/2017 11:27 am Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er ider Component Remuneration Component Component Hours 1. 00 2.00 3. 00 4.00 5. 00 6. 00 7.00 4. OO EMPLOYEE BENEFITS DEPARTMENT 31, 789 31, 789 1.00 179,000 1 00 0 318 2.00 5. 06 OTHER ADMINISTRATIVE AND 31, 252 0 31, 252 179,000 313 2.00 GENERAL 3.00 50. 00 OPERATING ROOM 360,000 360,000 0 3.00 4.00 53. 00 ANESTHESI OLOGY 2, 121, 954 1, 717, 230 404, 724 239, 400 2, 295 4.00 54. 00 RADI OLOGY-DI AGNOSTI C 5.00 888, 917 888, 917 Ω 5.00 6.00 56. 01 ONCOLOGY 162, 544 181, 290 18,746 271, 900 112 6.00 7.00 57. 00 CT SCAN 259 259 7.00 0 60. 00 LABORATORY 56, 886 8.00 Ω 56,886 260, 300 726 8.00 9.00 66. 00 PHYSI CAL THERAPY 10,000 0 10,000 179,000 96 9.00 10.00 69. 00 ELECTROCARDI OLOGY 57, 910 57, 910 0 10.00 11.00 90. OOLLI NI C 189.076 93.377 95, 699 179,000 520 11 00 14, 996 91. 00 EMERGENCY 12.00 675,000 660,004 179,000 3,480 12.00 200.00 4, 604, 333 3, 295, 233 1, 309, 100 7,860 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Cost of Provi der Physician Cost Limit Unadjusted RCE Memberships & of Malpractice I denti fi er Component Share of col Limit Conti nui ng Insurance Educati on 12 14. 00 1.00 2.00 8.00 9.00 12. 00 13.00 1.00 4. 00 EMPLOYEE BENEFITS DEPARTMENT 27, 366 1, 368 1. 00 5. 06 OTHER ADMINISTRATIVE AND 0 2.00 26, 936 1, 347 0 2.00 GENERAL 50.00 OPERATING ROOM 3.00 0 0 0 3.00 4.00 53. 00 ANESTHESI OLOGY 13, 207 0 264, 146 4.00 0 5.00 54. 00 RADI OLOGY-DI AGNOSTI C Ω 0 0 0 0 5.00 56. 01 ONCOLOGY 0 0 6.00 14,641 732 6.00 7.00 57. 00 CT SCAN 0 0 0 7.00 60. 00 LABORATORY 0 0 8.00 8.00 90, 855 4,543 9.00 66. 00 PHYSI CAL THERAPY 8, 262 413 0 0 0 9.00 69. 00 ELECTROCARDI OLOGY 10.00 10.00 0 0 0 11.00 90. 00 CLI NI C 44, 750 2, 238 0 0 11.00 12.00 91. 00 EMERGENCY 299, 481 14, 974 0 12.00 38, 822 ol 200.00 776, 437 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCE Adjustment I denti fi er Component Limit Di sal I owance Share of col 14 15. 00 2.00 1. 00 16.00 17. 00 18. 00 1.00 4.00 EMPLOYEE BENEFITS DEPARTMENT 27, 366 4, 423 4, 423 1.00 2.00 5. 06 OTHER ADMINISTRATIVE AND 26, 936 4, 316 4, 316 2.00 GENERAL 3.00 50. 00 OPERATING ROOM 360,000 3.00 53. 00 ANESTHESI OLOGY 4.00 0 264, 146 140, 578 1,857,808 4.00 54. 00 RADI OLOGY-DI AGNOSTI C 5.00 0 888, 917 5.00 56. 01 ONCOLOGY o 6.00 14, 641 4, 105 166, 649 6.00 7.00 57. 00 CT SCAN 0 7.00 0 259 60. 00 LABORATORY 0 90.855 8.00 (8.00 9.00 66. 00 PHYSI CAL THERAPY 0 8, 262 1,738 1,738 9.00 10.00 69. 00 ELECTROCARDI OLOGY 0 57, 910 10.00 44, 750 90. 00 CLI NI C 0 50, 949 144, 326 11.00 11 00 12.00 91. 00 EMERGENCY 299, 481 360, 523 375, 519 12.00

776, 437

566, 632

3, 861, 865

200.00

200.00

| Period: | Worksheet B | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0097

Cost Center Description						To 12/31/2016	Date/Time Pre	
COL 173		Cost Center Description	for Cost Allocation	RELATED COSTS	BENEFITS	COMMUNI CATI ONS	DATA	zi am
EMPRIAL SERVICE COST CEMTERS 1.00 ONDOOL OAP REL COSTS FLORE IS 61 SYT 1.00 ONDOOL OAP REL COSTS FLORE STEELY TO 10, 610, 327 1.00 COLOR OAP REL COSTS FLORE STEELY TO 10, 610, 327 1.00 COLOR OAP REL COSTS FLORE STEELY TO 10, 610, 327 1.00 COLOR OAP REL COSTS FLORE STEELY TO 10, 610, 327 1.00 COLOR OAP REL COSTS FLORE STEELY TO 10, 610, 327 1.00 COLOR OAP REL COSTS FLORE STEELY TO 10, 610, 327 1.00 COLOR OAP REL COSTS FLORE STEELY TO 10, 610, 327 1.00 COLOR OAP REL COSTS FLORE STEELY TO 10, 610, 510, 510, 510, 510, 510, 510, 510, 5			col. 7)					
1.00		CENEDAL CEDALOF COCT CENTEDS	0	1.00	4. 00	5. 01	5. 02	
0.0000 DEPLOYME SERVETTS DEPARTMENT	1 00		2 454 340	2 454 340	I			1 00
0.11 0.11						3		
0.0500 DURCHASHING, RECEIVING, AND STORES 355, 146 13,778 65,513 324 19,384 6,03 5.05 00500 CASH ERINGACCOUNTS RECEIVABLE 1,475, 160 0 111,005 0 0 00,842 5.06 5.06 00590 CASH ERINGACCOUNTS RECEIVABLE 1,475, 160 0 111,005 0 0 00,842 5.06 5.06 00590 CASH ERINGACCOUNTS RECEIVABLE 1,475, 160 0 0 0 0 0 0 0 0 0								
0.570 AMULTING 1.255, 399 30, 625 271, 702 892 193, 840 5, 05 500						,		
0.0860 CASH ERIN KOX-COCUNTS RECEIVABLE 1, 475, 160 0 111, 1005 0 322, 005 5.06 0.0932 0.0820 0.08			1	1				
0.000 0.00			1	1				
0.000 0.0000 DANIDERY & LINEN SERVICE 226, 381 10, 505 7, 621 0 6, 401 8, 00 10, 00 0.000 DETAWY 238, 149 46, 601 40, 720 40, 512, 76 10, 00 10, 10, 00 10, 00 0.000 DETAWY 238, 149 46, 601 40, 720 40, 512, 76 10, 00 10,			1	l .				
9.00 0.0900 MUSEKEPING 1,376, 962 4,864 217,300 162 174,456 9.00 11.00 0.1000 DETLAW 238,149 46,601 40,720 405 127,65 10.00 11.00 0.1000 MUSEN & ADMINI STRATION 687,123 31,856 132,004 1,500 40,59 13.00				1				1
10.00 10000 ICTARY 238, 149			1	l ·				
11-00 0 1100 (AFETERIA 461,374 73,800 103,383 0 0 11 1.00 130		l l	1	l .				1
14. 00 01400 CENTRAL SERVICES & SUPPLY 7, 807, 107, 108 240, 848 365 71, 075 15. 00 1500 PHARMACY 7, 1712, 085 240, 848 365 71, 075 15. 00 1500 PHARMACY 7, 1712, 085 240, 848 365 71, 075 15. 00 109, 729 649 109, 842 10. 00 109, 729 649 109, 842 10. 00 109, 729 649 109, 842 10. 00 109, 729 649 109, 842 10. 00 109, 729 641 109, 842 10. 00 109, 729 641 109, 842 10. 00 109, 729 641 109, 842 10. 00 109, 729 641 109			1	l ·				
15. DO 01500 PHARMARCY 7, 897, 197 27, 408 249, 484 365 71, 075 15. DO 109, 842 16. OO 1000 MDICAL RECORDS & LIBRARY 1.172, 085 141, 696 196, 729 649 109, 842 16. OO 1000 MUITS & PEDIATRICS 1.00 41. OO 4100 MUITS & PEDIATRICS 1.00 0.00			687, 123		1			
10 10 10 10 10 10 10 10			-	l ·				
INPATI ENT ROUTINE SERVICE COST CENTERS 6,694,084 459,439 1,404,752 3,080 594,441 30,00 31.00 30100 AURITS & PEDIATRICS 31.00 503100 INTERIST WE CARRE LINIT 1,489,132 140,691 275,044 770 122,765 31.00 41.00 410.00			1		1			1
31.00 03100 INTENSIVE CARE UNIT 1, 489, 132 140, 691 275, 044 770 122, 765 31.00 41.00 410.00 4100 SUBPROVIDER	10.00		1,172,000	11,070	170,727	, 017	107,012	10.00
11 00 04100 SUBPROVIDER - IRF								1
ABOUT ABOU								1
MACILLARY SERVICE COST CENTERS			-					1
S2.00 05200 DELEVERY ROOM & LABOR ROOM 0 0 0 0 0 5.5.0	12.00					<u>γ</u>		12.00
1.1			4, 310, 736	184, 320				
54.00 05400 RADIO LOGY-PI ACNOSTIC 4, 017, 153 175, 897 554, 735 973 219, 685 54.00 56.00 05600 RADIO SOTOPE 0 0 0 0 0 6.6.00 056.00 05600 RADIO SOTOPE 0 0 0 0 0 6.6.00 056.00			1 119 007	0 015	-	-		
56.00 05600 RADIO II SOTOPE								1
17.00 05700 05700 05700 05700 0500 06700 07.00				0				1
S8. 00 OSBOO MAGNETIC RESONANCE IMACING (MRI) 672, 139 0 88, 977 0 25, 845 88, 00 0 0 0 0 0 0 0 0 0								
59.00 05900 CARDIAC CATHETERI ZATION 0 0 0 0 0 0 0 0 0			1	1				
60.0 0 66000 LABORATORY			6/2, 139	0	85, 977			
65.01 06500 RESPI RATORY THERAPY 6.00 06500 RESPI RATORY THERAPY 6.01 06600 PHYSI CAL THERAPY 6.02 0 06900 ELECTROCARDI OLOGY 6.00 06900 ELECTROCARDI OLOGY 6.00 06900 ELECTROCARDI OLOGY 6.00 06900 ELECTROCARDI OLOGY 6.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			4, 532, 339	37, 951	442, 561	892		1
65.01 06501 SLEEP LAB			0	0	C	o		1
66.00 06600 PHYSICAL THERAPY 1,842,664 11,925 336,250 973 129,226 66.00 69.00 06900 ELECTROCARDI OLOGY 604,065 53,434 129,730 0 64,613 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1,746,931 0 16,569 0 19,384 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2,084,102 0 15,569 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 88.00 08800 RURAL HEALTH CLINI C 0 0 0 0 0 0 0 0 89.00 08900 FEBERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 90.00 09000 CLINI C 3,674,030 100,337 652,770 851 232,608 91.00 91.00 09100 EMERGENCY 3,674,030 100,337 652,770 851 232,608 91.00 92.00 09200 09SERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 97.00 09700 DURABLE MEDICAL EQUIP -SOLD 0 0 0 0 0 0 0 0 101.00 10000 1&R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 0 0 97.00 09700 MURBUL RACE SERVI CES 0 0 0 0 0 0 0 0 90.00 101.00 10100 1 1 1 1 1 1 1			1	l ·				
69.0 06900		l l	1	l .				
72. 00 07200 IMPL DEV. CHARGED TO PATIENT 2,084,102 0 15,959 0 0 0 72. 00			1	l .	1			
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00				0				
SECOND CONTROL CONTR			1					
88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89.00 90.00 09000 CLINIC 61,432 94,583 64,156 689 25,845 90.00 91.00 09100 EMERGENCY 3,674,030 100,337 652,770 851 232,608 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 92.00 07HER REI MBURSABLE COST CENTERS 92.00 07HOUD DURABLE MEDI CAL EQUIP-SOLD 0 0 0 0 0 0 100.00 10000 18R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 0 101.00 1000 18R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 0 101.00 10100 HOME HEALTH AGENCY 1,335,622 0 194,565 0 77,536 101.00 113.00 113.00 118EST EXPENSE 113.00 118.00 NONREI MBURSABLE COST CENTERS 113.00 118.00 119.00	73.00			0		<u> </u>	0	73.00
90. 00 09000 CLI NI C 61, 432 94, 583 64, 156 689 25, 845 90. 00 91. 00 91. 00 91. 00 MERGENCY 3, 674, 030 100, 337 652, 770 851 232, 608 91. 00 92. 00 09200 BERSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 00 00 00 00 00 00 00		08800 RURAL HEALTH CLINIC	0	0	C	0		
91. 00 09100 EMERGENCY 3, 674, 030 100, 337 652, 770 851 232, 608 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 00 00 00 00 00 00 00			1	_	(4.45)	-		1
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0								
OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0,071,000	100,007	002,770		202, 000	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 0 0 0 0 0 0 0 0 1000.00 1 8 SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 0 0 0 100.00 1 000.00 1 1 000.00		OTHER REIMBURSABLE COST CENTERS		1				
100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM 0 0 0 100. 00 101. 00 10			0	0				
101.00 10100 HOME HEALTH AGENCY 1, 335, 622 0 194, 565 0 77, 536 101.00				0				
113. 00			1, 335, 622	Ö	194, 565			1
118. 00 SUBTOTALS (SUM OF LINES 1-117) 81, 069, 667 2, 390, 392 9, 599, 437 20, 834 3, 670, 031 118. 00								
NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 7,041 0 0 0 190.00			01 0/0 //7	2 200 202	0 500 437	7 20 024	2 (70 021	
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 7, 041 0 0 190. 00 190. 01 19001 SHELBY COUNTY MEDI CAL CENTER 0 0 0 0 190. 01 190. 02 19002 SI CK CHI LD CARE 0 0 0 0 0 190. 02 190. 03 19003 PRI VATE DUTY 0 0 0 0 0 190. 03 190. 04 19004 ST. VI NCENT'S STRESS 0 0 0 0 0 190. 04 190. 05 19005 MARKETI NG 374, 290 3, 634 47, 040 0 12, 923 190. 05 190. 06 19006 MH LI GHTBOUND 0 0 0 0 190. 06 190. 06 19006 MH LI GHTBOUND 0 0 0 0 0 190. 07 190. 07 19007 1 -74 CAMPUS 398, 424 0 29, 954 0 32, 307 190. 07 190. 07 190. 07 19008 SOUTHEAST OB 0 0 0 0 0 190. 08 190. 09 19009 INTELLI PLEX DEVELOPMENT 69, 455 0 526 0 0 190. 09 190. 10	118.00		81,009,007	2, 390, 392	9, 599, 437	20, 834	3, 670, 031] 118.00
190. 02 19002 SI CK CHI LD CARE 0 0 0 0 0 0 190. 02 190. 03 19003 PRI VATE DUTY 0 0 0 0 0 190. 03 19004 ST. VI NCENT'S STRESS 0 0 0 0 0 0 190. 04 190. 05 19005 MARKETI NG 374, 290 3, 634 47, 040 0 12, 923 190. 05 190. 06 19006 MH LI GHTBOUND 0 0 0 0 0 0 190. 06 190. 07 190. 07 190. 07 190. 07 190. 07 190. 08 19008 SOUTHEAST OB 0 0 0 0 0 0 190. 08 190. 08 19009 I NTELLI PLEX DEVELOPMENT 69, 455 0 526 0 0 190. 10 190. 10 1901 MMG	190.00		0	7, 041		0	0	190. 00
190. 03 19003 PRI VATE DUTY			0	0	C	0		
190. 04 19004 ST. VINCENT'S STRESS 0 0 0 0 0 0 190. 04 190. 05 19005 MARKETING 374, 290 3, 634 47, 040 0 12, 923 190. 05 190. 06 190. 06 190. 06 190. 07 19007 1-74 CAMPUS 398, 424 0 29, 954 0 32, 307 190. 07 19008 SOUTHEAST OB 0 0 0 0 0 0 0 190. 08 190. 08 190. 09 190. 10 190. 10 19010 MMG 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 190. 10		1	0	0				
190. 05 19005 MARKETI NG 374, 290 3, 634 47, 040 0 12, 923 190. 05 190. 06 190. 06 190. 06 190. 07 19007 1 -74 CAMPUS 398, 424 0 29, 954 0 32, 307 190. 07 190. 08 190. 09 19009 INTELLI PLEX DEVELOPMENT 69, 455 0 0 0 0 190. 10 19010 MMG 0 0 0 0 190. 10 190. 10 10 10 10 10 10 10 10				0				
190. 07 19007 1-74 CAMPUS 398, 424 0 29, 954 0 32, 307 190. 07 190. 08 19008 SOUTHEAST OB 0 0 0 0 190. 08 190. 09 19009 INTELLI PLEX DEVELOPMENT 69, 455 0 526 0 0 190. 09 190. 10 19010 MMG 0 0 0 0 0 0 0 190. 10			374, 290	3, 634	47, 040	ol ol		
190. 08 19008 SOUTHEAST OB			0	0	0			
190. 09 19009 NTELLI PLEX DEVELOPMENT 69, 455 0 526 0 0 190. 09 190. 10 19010 MMG 0 0 0 0 0 190. 10			398, 424	0	29, 954	0		
190. 10 19010 MMG 0 0 0 0 190. 10			69. 455	0	526			
190. 11 19011 0THER NON-REI MBURSEABLE CENTERS 0 0 0 0 190. 11	190. 10	19010 MMG		l .	320	ol ől	0	190. 10
	190. 11	1 19011 OTHER NON-REIMBURSEABLE CENTERS	0	0	(o o	0	190. 11

Peri od: Worksheet B From 01/01/2016 Part I To 12/31/2016 Date/Time Prepared:

					5/25/2017 11:	27 am_
		CAPITAL RELATED COSTS				
Cost Center Description	Net Expenses	BLDG & FIXT	EMPLOYEE	COMMUNI CATI ONS	DATA	
	for Cost		BENEFITS		PROCESSI NG	
	Allocation		DEPARTMENT			
	(from Wkst A					
	col. 7)					
	0	1. 00	4. 00	5. 01	5. 02	
190. 12 19012 BARTLEY ORTHOPEDICS	0	0	C	0	0	190. 12
190. 13 19013 SSA	0	0	C	0	0	190. 13
190. 14 19014 SPORTSWORKS	0	0	C	0	0	190. 14
190. 15 19015 SHELBY PEDS	0	0	C	0	0	190. 15
190. 16 19016 RENOVO	1, 369, 220	0	66, 328	0	0	190. 16
190. 17 19017 I MA	0	0	C	0	0	190. 17
190. 18 19018 MD SOLUTIONS	905, 078	0	100, 218	0	0	190. 18
190. 19 19019 MHCD	1, 403, 102	4, 997	C	0	0	190. 19
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	C	0	0	192. 00
192. 01 19201 HOSPI TALI ST	2, 934, 650	0	605, 399	41	58, 152	192. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	896, 676	48, 285	171, 646	608	64, 613	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		o	C	o	0	201. 00
202.00 TOTAL (sum lines 118-201)	89, 420, 562	2, 454, 349	10, 620, 548	21, 483	3, 838, 026	202. 00

Provider CCN: 15-0097

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2016 | Part I | To 12/31/2016 | Date/Time Prepared: | 5/25/2017 11: 27 am

					12/31/2010	5/25/2017 11:	
	Cost Center Description	PURCHASI NG,	ADMI TTI NG	CASHI ERI NG/ACC	Subtotal	OTHER	
		RECEIVING, AND		OUNTS		ADMI NI STRATI VE	
		STORES	F 04	RECEI VABLE	EA OF	AND GENERAL	
CEN	NERAL SERVICE COST CENTERS	5. 03	5. 04	5. 05	5A. 05	5. 06	
	100 CAP REL COSTS-BLDG & FLXT						1.00
	400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	160 COMMUNI CATI ONS						5. 01
	550 DATA PROCESSING						5. 02
	590 PURCHASING, RECEIVING, AND STORES	454, 165					5. 03
	570 ADMI TTI NG	4, 919	1, 737, 377	7			5. 04
	580 CASHI ERI NG/ACCOUNTS RECEI VABLE	3, 105	.,,	1, 699, 202			5. 05
	592 OTHER ADMINISTRATIVE AND GENERAL	9, 393	C		10, 275, 932	10, 275, 932	5. 06
	700 OPERATION OF PLANT	989	C	o	2, 975, 979		7. 00
8.00 008	800 LAUNDRY & LINEN SERVICE	32	C	o	251, 000	l	8. 00
9.00 000	900 HOUSEKEEPI NG	8, 587	C	o	1, 782, 331	231, 413	9. 00
10.00 010	000 DI ETARY	3, 529	C	0	452, 169	58, 708	10. 00
	100 CAFETERI A	0	C	0	638, 557	82, 908	11. 00
	300 NURSING ADMINISTRATION	7, 892	C	0	950, 834		13. 00
	400 CENTRAL SERVICES & SUPPLY	18, 593	C	0	98, 390	12, 775	14. 00
	500 PHARMACY	5, 086	C	0	8, 250, 615		15. 00
	600 MEDICAL RECORDS & LIBRARY	3, 520	C	0	1, 524, 523	197, 939	16. 00
	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDI ATRI CS	39, 896	102, 449		9, 398, 346		30. 00
1	100 I NTENSI VE CARE UNI T	27, 390	23, 254		2, 101, 791	272, 890	31.00
	100 SUBPROVI DER – I RF	0	C		0	0	41.00
	200 SUBPROVI DER	0)	0	0	42. 00
	CILLARY SERVICE COST CENTERS	11/ 070	242.077	227 (55	/ 1E1 00/	700 725	 EO OO
	000 OPERATING ROOM 200 DELIVERY ROOM & LABOR ROOM	116, 978	242, 977	237, 655	6, 151, 826	798, 735 0	50. 00 52. 00
	300 ANESTHESI OLOGY	26, 826	31, 439	1	1, 900, 127	246, 707	53.00
	400 RADI OLOGY-DI AGNOSTI C	11, 209	136, 965		5, 250, 583	l	54.00
	600 RADI OI SOTOPE	11, 207	130, 900	133, 700	J, 230, 303	001, 720	56. 00
	601 ONCOLOGY	15, 611	62, 852	61, 476	2, 664, 760	1	56. 01
	700 CT SCAN	4, 984	129, 579		1, 252, 173	l	57. 00
	800 MAGNETIC RESONANCE IMAGING (MRI)	2, 165	58, 073		901, 000		58.00
	900 CARDI AC CATHETERI ZATI ON	2, 103	30, 07	30,001	701, 000 N	0	59.00
	000 LABORATORY	45, 398	218, 851	214, 058	5, 750, 503		60.00
	001 BLOOD LABORATORY	10, 0,0	210,001	211,000	0, 700, 000	0	60. 01
	500 RESPI RATORY THERAPY	7, 623	29, 526	28, 880	1, 393, 183	180, 887	65. 00
	501 SLEEP LAB	4, 195	24, 832	1	806, 022		•
1	600 PHYSI CAL THERAPY	8, 140	41, 606		2, 461, 479	l	66.00
	900 ELECTROCARDI OLOGY	8, 620	32, 905		925, 552		69. 00
71. 00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	117, 294	114, 726	2, 014, 904	261, 609	71. 00
72. 00 072	200 IMPL. DEV. CHARGED TO PATIENT	o	C	o	2, 100, 061	272, 666	72. 00
73. 00 073	300 DRUGS CHARGED TO PATIENTS	0	163, 892	160, 303	324, 195	42, 093	73. 00
	TPATIENT SERVICE COST CENTERS						
	800 RURAL HEALTH CLINIC	0	C	0	0	0	88. 00
	900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	0	0	0	89. 00
	000 CLI NI C	1, 617	776		249, 857	32, 441	
	100 EMERGENCY	44, 549	250, 023	244, 419	5, 199, 587	1	1
	200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92. 00
	HER REIMBURSABLE COST CENTERS						05.00
	500 AMBULANCE SERVI CES	0	C		0	0	95. 00
	700 DURABLE MEDICAL EQUIP-SOLD 000 I&R SERVICES-NOT APPRVD PRGM	0			0	0	97. 00 100. 00
	100 HOME HEALTH AGENCY	8, 526	12, 740	12, 461	1, 641, 450		
	ECIAL PURPOSE COST CENTERS	0, 320	12, 740	12,401	1, 041, 430	213, 121	101.00
	300 INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	439, 372	1, 680, 033	1, 643, 113	79, 687, 729	9, 012, 250	
	NREI MBURSABLE COST CENTERS	437,372	1,000,000	1, 043, 113	17,007,727	7,012,230	1110.00
	OOO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	7, 041	914	190. 00
	001 SHELBY COUNTY MEDICAL CENTER	o	C		0		190. 01
	002 SICK CHILD CARE	o	C		0		190. 02
	003 PRI VATE DUTY	0	C		0	l e	190. 03
	004 ST. VINCENT'S STRESS	0	C	o	0	0	190. 04
1	005 MARKETI NG		C		437, 887	56, 854	•
190. 06 190	006 MH LIGHTBOUND	o	C	o	0	0	190. 06
	007 I-74 CAMPUS	88	C	0	460, 773	59, 825	190. 07
	008 SOUTHEAST OB	0	C	0	0		190. 08
	009 INTELLIPLEX DEVELOPMENT	0	C	0	69, 981		190. 09
190. 10 190	l e e e e e e e e e e e e e e e e e e e	0	C		0	•	190. 10
	O11 OTHER NON-REIMBURSEABLE CENTERS	0	C		0	•	190. 11
	012 BARTLEY ORTHOPEDICS	0	C		0	•	190. 12
190. 13 190	l e e e e e e e e e e e e e e e e e e e		C		0	•	190. 13
	014 SPORTSWORKS	0	C -		0	•	190. 14
190. 15 190	015 SHELBY PEDS	0	С	<u>ار</u>	0	1 0	190. 15

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS MAJOR HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0097

Peri od: Worksheet B
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared: 5/25/2017 11: 27 am

	Cost Center Description	PURCHASI NG,	ADMITTING	CASHI ERI NG/ACC	Subtotal	OTHER	
		RECEIVING, AND		OUNTS		ADMI NI STRATI VE	
		STORES		RECEI VABLE		AND GENERAL	
		5. 03	5. 04	5. 05	5A. 05	5. 06	
190. 16 19016	RENOVO	236	0	0	1, 435, 784	186, 418	190. 16
190. 17 19017	I MA	0	0	0	0	0	190. 17
190. 18 19018	MD SOLUTIONS	0	0	0	1, 005, 296	130, 525	190. 18
190. 19 19019	MHCD	0	31, 913	31, 214	1, 471, 226	191, 020	190. 19
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
192. 01 19201	HOSPI TALI ST	58	16, 596	16, 233	3, 631, 129	471, 455	192. 01
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	14, 411	8, 835	8, 642	1, 213, 716	157, 585	194. 00
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)	454, 165	1, 737, 377	1, 699, 202	89, 420, 562	10, 275, 932	202. 00

Provider CCN: 15-0097

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared: 5/25/2017 11: 27 am

					12/01/2010	5/25/2017 11:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE				
	DENERAL DERIVACE DOOT DENTERO	7.00	8. 00	9. 00	10. 00	11. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 4. 00	OO100 CAP REL COSTS-BLDG & FIXT OO400 EMPLOYEE BENEFITS DEPARTMENT						1. 00 4. 00
4. 00 5. 01	01160 COMMUNI CATI ONS						5. 01
5. 01	00550 DATA PROCESSING						5. 02
5. 02	00590 PURCHASING, RECEIVING, AND STORES						5. 02
5. 03	00570 ADMITTING						5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 04
5. 06	00592 OTHER ADMINISTRATIVE AND GENERAL						5. 06
7. 00	00700 OPERATION OF PLANT	3, 362, 371					7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	17, 963	301, 552				8.00
9. 00	00900 HOUSEKEEPI NG	8, 318	301, 332				9.00
10. 00	01000 DI ETARY	79, 686	0	_, -,,	638, 862		10.00
11. 00	01100 CAFETERI A	126, 196	0	76, 490	030, 002	924, 151	
13. 00	01300 NURSING ADMINISTRATION	54, 472	0	33, 017	0	15, 655	
14. 00	01400 CENTRAL SERVICES & SUPPLY	102, 957	0	62, 404	0	0 15,055	14. 00
15. 00	01500 PHARMACY	46, 866	0	28, 407	0	26, 658	1
	01600 MEDICAL RECORDS & LIBRARY	71, 303	0	· ·	0	36, 881	1
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	71,303	0	43, 210	<u> </u>	30,001	10.00
30. 00	03000 ADULTS & PEDIATRICS	785, 627	104, 411	476, 180	571, 536	205, 638	30.00
31. 00	03100 INTENSIVE CARE UNIT	240, 579	16, 085		67, 326	42, 563	
41. 00	04100 SUBPROVI DER - I RF	240, 377	10,003	143, 617	07, 320	1 42, 303	1
42. 00	04200 SUBPROVI DER	0	0	0	0	0	42.00
42.00	ANCI LLARY SERVI CE COST CENTERS	0	U	<u> </u>	0	0	42.00
50. 00	05000 OPERATING ROOM	315, 183	50, 213	191, 038	0	102, 937	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0 0	0 0	0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	15, 245	0	9, 240	0	15, 775	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	300, 780	35, 358		0	70, 640	1
56. 00	05600 RADI OI SOTOPE	300, 700	33, 330 0	102, 500	0	0	56.00
56. 01	05601 0NC0L0GY	537, 863	8, 278	١	0	38, 748	1
57. 00	05700 CT SCAN	12, 947	0, 270	7, 847	0	11, 377	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	12, 747	0	7,047	0	10, 951	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0,731	59. 00
60. 00	06000 LABORATORY	64, 894	6	39, 334	0	84, 369	1
60. 01	06001 BLOOD LABORATORY	01,071	0	0,,001	0	01,007	60. 01
65. 00	06500 RESPI RATORY THERAPY	27, 058	3, 013	16, 400	0	26, 415	
65. 01	06501 SLEEP LAB	0	0,0.0	0	0	0	1
66. 00	06600 PHYSI CAL THERAPY	20, 391	11, 424	12, 359	0	46, 995	
69. 00	06900 ELECTROCARDI OLOGY	91, 370	0.1, 121	55, 381	0	20, 356	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	71, 370	0	0	0	4, 708	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	ő	0	0	0	4, 329	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	ő	0	0	0	0	1
70.00	OUTPATIENT SERVICE COST CENTERS			<u> </u>	<u> </u>		70.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1	0	o o	89. 00
90. 00	09000 CLINIC	161. 734	1, 044	-	0	10, 075	1
91. 00	09100 EMERGENCY	171, 574	71, 720	· ·	0	89, 900	1
92. 00		,	, . = -	,	_	.,,,,,,,,	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95. 00	09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	ı
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0	o	0	Ō	100.00
	10100 HOME HEALTH AGENCY	0	0	o	0		101. 00
	SPECIAL PURPOSE COST CENTERS				-		
113.00	11300 NTEREST EXPENSE						113. 00
118.00	1	3, 253, 006	301, 552	1, 955, 773	638, 862	864, 970	1
	NONREI MBURSABLE COST CENTERS	., ., .,		, , , , , ,			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	12, 040	0	7, 298	0	0	190. 00
	19001 SHELBY COUNTY MEDICAL CENTER	0	0	0	0		190. 01
	19002 SICK CHILD CARE	0	0	0	0		190. 02
	19003 PRI VATE DUTY	0	0	0	0		190. 03
	19004 ST. VINCENT'S STRESS	0	0	0	0		190. 04
	19005 MARKETI NG	6, 214	0	3, 767	0		190. 05
	19006 MH LI GHTBOUND	0	0	0	0		190. 06
	19007 I -74 CAMPUS	0	n	ا	n		190. 07
	19008 SOUTHEAST OB	0	n	ا	0		190. 08
	19009 I NTELLI PLEX DEVELOPMENT	l o	0	0	n		190. 09
	19010 MMG		0		0		190. 10
	19011 OTHER NON-REIMBURSEABLE CENTERS		0		0		190. 10
	19012 BARTLEY ORTHOPEDICS		0		0		190. 11
	19013 SSA		0		0		190. 12
	19014 SPORTSWORKS		0		0		190. 13
	19015 SHELBY PEDS		0		0		190. 14
	19016 RENOVO		0	0	0		190. 16
	1 1	<u> </u>		. 9	<u> </u>	.0,070	1

Heal th Financial Systems MAJOR HOSPITAL In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0097
From 01/01/2016
To 12/31/2016
Date/Time Prepared:

					5/25/2017 11:	27 am
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE				
	7. 00	8. 00	9. 00	10.00	11. 00	
190. 17 19017 I MA	0	0	0	0	0	190. 17
190. 18 19018 MD SOLUTIONS	0	0	0	0	0	190. 18
190. 19 19019 MHCD	8, 545	0	5, 179	0	0	190. 19
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
192. 01 19201 HOSPI TALI ST	0	0	0	0	26, 005	192. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	82, 566	0	50, 045	0	0	194. 00
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)	3, 362, 371	301, 552	2, 022, 062	638, 862	924, 151	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CC	Fr	eriod: rom 01/01/2016		
				To		5/25/2017 11:	pared: 27 am
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDICAL RECORDS &	Subtotal	
		ADMINI STRATION	SUPPLY		LI BRARY		
	CENEDAL SERVICE COST CENTERS	13.00	14. 00	15. 00	16. 00	24. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5. 03 5. 04	00590 PURCHASING, RECEIVING, AND STORES 00570 ADMITTING						5. 03 5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00592 OTHER ADMINISTRATIVE AND GENERAL						5. 06
7.00	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8. 00 9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1, 177, 431	27/ 52/				13. 00 14. 00
15. 00	01500 PHARMACY		276, 526 0	9, 423, 781			15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	Ö	Ö	0	1, 873, 864		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	360, 271 74, 569	0	0	121, 460 23, 368	13, 243, 753 2, 984, 990	
41. 00	04100 SUBPROVI DER – I RF	74, 309	o	0	23, 300	2, 904, 990	1
42.00	04200 SUBPROVI DER	0	O	0	0	0	1
FO 00	ANCI LLARY SERVI CE COST CENTERS	100 242	ما	0	272 027	0.0/2.212	F0 00
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	180, 343	0	0	272, 037 0	8, 062, 312 0	1
53. 00	05300 ANESTHESI OLOGY	27, 638	o	0	9, 719	2, 224, 451	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	o	0	154, 866	6, 676, 255	
56.00	05600 RADI OI SOTOPE	0	0	0	71 0/7	0 0 0 0 0	56.00
56. 01 57. 00	05601 0NCOLOGY	67, 886	0	0	71, 067 146, 515	4, 060, 594 1, 593, 437	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	o	o	0	65, 662	1, 094, 596	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	o	0	0	0	59. 00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	0	0	247, 454	6, 933, 188	60. 00 60. 01
65. 00	06500 RESPIRATORY THERAPY	46, 278	o	0	33, 385	1, 726, 619	1
65. 01	06501 SLEEP LAB	25, 442	Ō	Ō	28, 077	964, 192	
66.00	06600 PHYSI CAL THERAPY	0	0	0	47, 044	2, 919, 283	1
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	35, 663	0 141, 028	0	37, 206 67, 556	1, 285, 699 2, 489, 805	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT		135, 498	0	65, 069	2, 577, 623	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	9, 423, 781	185, 312	9, 975, 381	73. 00
00 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		ما	ol	٥	0	00 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		
	09000 CLI NI C	17, 652	ō	Ō	878	571, 711	
		157, 501	0	0	282, 784	6, 752, 159	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	o	0	0	0	
	10000 I&R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	0 47, 542	0	0	0 14, 405	0 1, 916, 518	100.00
101.00	SPECIAL PURPOSE COST CENTERS	47, 542	<u> </u>	U _I	14, 405	1, 910, 516	1101.00
	11300 INTEREST EXPENSE						113. 00
118.00		1, 040, 785	276, 526	9, 423, 781	1, 873, 864	78, 052, 566	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		ol	0	0	27 293	190. 00
	19001 SHELBY COUNTY MEDICAL CENTER	o	o	0	Ö		190. 01
	19002 SICK CHILD CARE	0	o	0	0		190. 02
	3 19003 PRI VATE DUTY	0	0	0	0		190. 03
	19004 ST. VINCENT'S STRESS 19005 MARKETING		0	0	o n	504, 722	190. 04 190. 05
	19006 MH LI GHTBOUND		ő	Ö	ő		190. 06
	19007 I -74 CAMPUS	14, 412	o	0	o	543, 236	
	3 19008 SOUTHEAST OB	0	0	0	0		190. 08 190. 09
	P 19009 INTELLIPLEX DEVELOPMENT 19010 MMG	206	0	0	0		190. 09
190. 11	19011 OTHER NON-REIMBURSEABLE CENTERS		ő	Ö	ő	0	190. 11
	19012 BARTLEY ORTHOPEDICS	0	o	0	o		190. 12
	3 19013 SSA 1 19014 SPORTSWORKS	0	0	0	0		190. 13 190. 14
	19015 SHELBY PEDS		o	0	0		190. 14
	· · · · · · · · · · · · · · · · · · ·						

Health Financial Systems MAJOR HOSPITAL In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0097
From 01/01/2016
From 01/01/2016
To 12/31/2016
Date/Time Prepared:

					5/25/2017 11:	27 am_
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Subtotal	
	ADMI NI STRATI ON	SERVICES &		RECORDS &		
		SUPPLY		LI BRARY		
	13. 00	14.00	15. 00	16. 00	24.00	
190. 16 19016 RENOVO	32, 232	0	0	0	1, 672, 832	190. 16
190. 17 19017 I MA	0	0	0	0	0	190. 17
190. 18 19018 MD SOLUTIONS	0	0	0	0	1, 135, 821	190. 18
190. 19 19019 MHCD	o	0	0	0	1, 675, 970	190. 19
192.00 19200 PHYSICIANS' PRIVATE OFFICES	o	0	0	0	0	192. 00
192. 01 19201 HOSPI TALI ST	45, 561	0	0	0	4, 174, 150	192. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	44, 235	0	0	0	1, 548, 147	194. 00
200.00 Cross Foot Adjustments					0	200. 00
201.00 Negative Cost Centers	o	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	1, 177, 431	276, 526	9, 423, 781	1, 873, 864	89, 420, 562	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared: 5/25/2017 11: 27 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0097

			5/25/2017	
Cost Center Description	Intern &	Total		
	Residents Cost			
	& Post			
	Stepdown			
	Adjustments			
CENEDAL CEDALCE COCT CENTEDO	25. 00	26. 00		
GENERAL SERVICE COST CENTERS				1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT				1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 01 01160 COMMUNI CATI ONS 5. 02 00550 DATA PROCESSI NG				5. 01 5. 02
5. 03 00590 PURCHASING, RECEIVING, AND STORES				5. 02
5. 04 00570 ADMI TTI NG				5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE				5. 05
5. 06 00592 OTHER ADMINISTRATIVE AND GENERAL				5. 06
7. 00 00700 OPERATION OF PLANT				7. 00
8.00 00800 LAUNDRY & LINEN SERVICE				8. 00
9. 00 00900 HOUSEKEEPI NG				9. 00
10. 00 01000 DI ETARY				10. 00
11. 00 01100 CAFETERI A				11. 00
13.00 01300 NURSING ADMINISTRATION				13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY				14. 00
15. 00 01500 PHARMACY				15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY				16. 00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	0	13, 243, 753		30. 00
31. 00 03100 INTENSI VE CARE UNI T	0	2, 984, 990		31. 00
41. 00 04100 SUBPROVI DER - I RF	0	0		41. 00
42. 00 04200 SUBPROVI DER	0	0		42. 00
ANCILLARY SERVICE COST CENTERS		0.040.040		
50. 00 05000 OPERATING ROOM	0	8, 062, 312		50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53. 00 05300 ANESTHESI OLOGY	0	2, 224, 451		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	O O	6, 676, 255		54.00
56. 00 05600 RADI OI SOTOPE	0	4 040 504		56.00
56. 01 05601 0NCOLOGY 57. 00 05700 CT SCAN	0	4, 060, 594 1, 593, 437		56. 01 57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		1, 094, 596		58.00
59. 00 05900 CARDIAC CATHETERIZATION		1,094,590		59.00
60. 00 06000 LABORATORY	i i	6, 933, 188		60.00
60. 01 06001 BLOOD LABORATORY	ام	0, 700, 100		60. 01
65. 00 06500 RESPI RATORY THERAPY		1, 726, 619		65. 00
65. 01 06501 SLEEP LAB		964, 192		65. 01
66. 00 06600 PHYSI CAL THERAPY	l ol	2, 919, 283		66. 00
69. 00 06900 ELECTROCARDI OLOGY	o	1, 285, 699		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	rs o	2, 489, 805		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	o	2, 577, 623		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	О	9, 975, 381		73. 00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89. 00
90. 00 09000 CLI NI C	0	571, 711		90. 00
91. 00 09100 EMERGENCY	. 0	6, 752, 159		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	T) 0			92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		95. 00
	0	0		97.00
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	1 01/ 510		100.00
101.00 10100 HOME HEALTH AGENCY	0	1, 916, 518		101. 00
SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE				113. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	0	78, 052, 566		118.00
NONREI MBURSABLE COST CENTERS		70,032,300		110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEE	N O	27, 293		190. 00
190. 01 19001 SHELBY COUNTY MEDICAL CENTER	, 0	27,270		190. 01
190. 02 19002 SICK CHILD CARE	ام	0		190. 02
190. 03 19003 PRI VATE DUTY		ol		190. 03
190. 04 19004 ST. VINCENT'S STRESS	o	O		190. 04
190. 05 19005 MARKETI NG	0	504, 722		190. 05
190. 06 19006 MH LI GHTBOUND	0	6, 434		190. 06
190.07 19007 I -74 CAMPUS	0	543, 236		190. 07
190. 08 19008 SOUTHEAST OB	0	0		190. 08
190. 09 19009 I NTELLI PLEX DEVELOPMENT	0	79, 391		190. 09
190. 10 19010 MMG	0	0		190. 10
190. 11 19011 OTHER NON-REIMBURSEABLE CENTERS	0	0		190. 11
190. 12 19012 BARTLEY ORTHOPEDICS	0	0		190. 12
190. 13 19013 SSA	0	0		190. 13

Health Financial Systems	MAJOR HOS	SPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider Co	CN: 15-0097	From 01/01/2016	Worksheet B Part I Date/Time Pre 5/25/2017 11:	
Cost Center Description	Intern & Residents Cost & Post	Total				

			5/25/201/ 11: 2/ am
Cost Center Description	Intern &	Total	
	Residents Cost		
	& Post		
	Stepdown		
	Adjustments		
	25. 00	26.00	
190. 14 19014 SPORTSWORKS	0	0	190. 14
190. 15 19015 SHELBY PEDS	0	0	190. 15
190. 16 19016 RENOVO	0	1, 672, 832	190. 16
190. 17 19017 I MA	0	0	190. 17
190. 18 19018 MD SOLUTIONS	0	1, 135, 821	190. 18
190. 19 19019 MHCD	0	1, 675, 970	190. 19
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	192. 00
192. 01 19201 HOSPI TALI ST	0	4, 174, 150	192. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	1, 548, 147	194. 00
200.00 Cross Foot Adjustments	0	0	200. 00
201.00 Negative Cost Centers	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	0	89, 420, 562	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0097

				1	o 12/31/2016	Date/lime Pre 5/25/2017 11:	
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	
	T.	0	1.00	2A	4. 00	5. 01	
1 00	GENERAL SERVICE COST CENTERS			I		1	1 00
1. 00 4. 00 5. 01 5. 02 5. 03 5. 04	OO100 CAP REL COSTS-BLDG & FIXT	0 0 0 0	10, 221 5, 508 12, 833 13, 798 30, 625	12, 833 13, 798	289 63	83	1. 00 4. 00 5. 01 5. 02 5. 03 5. 04
5. 05 5. 06 7. 00 8. 00	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00592 OTHER ADMINISTRATI VE AND GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LINEN SERVICE	0 0 0	200, 882 214, 151 10, 505	0 200, 882 214, 151	107 1, 275 239	0 426	5. 05 5. 06 7. 00 8. 00
9. 00 10. 00 11. 00 13. 00	00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMINI STRATI ON	0 0 0	4, 864 46, 601 73, 800 31, 856	4, 864 46, 601 73, 800	209 39 100	42 104 0	9. 00 10. 00 11. 00 13. 00
14. 00 15. 00 16. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0 0	60, 210 27, 408	60, 210 27, 408	240 240	52 94	14. 00 15. 00 16. 00
30. 00 31. 00 41. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	0 0	459, 439 140, 691 0	140, 691 0	265 C	198 0	30. 00 31. 00 41. 00
42. 00	04200 SUBPROVI DER ANCI LLARY SERVI CE COST CENTERS	0	0	0	C) 0	42. 00
50. 00 52. 00 53. 00	05000 OPERATI NG ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0 0	0	0	_	0	50. 00 52. 00 53. 00
54. 00 56. 00 56. 01 57. 00	05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE 05601 ONCOLOGY 05700 CT SCAN	0 0 0	175, 897 0 314, 545 7, 571	175, 897 0 314, 545 7, 571	535 0 269 86	0 510	54. 00 56. 00 56. 01 57. 00
58. 00 59. 00 60. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY	0 0	0 0 37, 951	0 0 37, 951	83 C 427	0	58. 00 59. 00 60. 00
60. 01 65. 00 65. 01 66. 00	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY 06501 SLEEP LAB 06600 PHYSI CAL THERAPY	0 0 0	0 15, 824 0 11, 925	0	103	42	60. 01 65. 00 65. 01 66. 00
69. 00 71. 00 72. 00 73. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0 0	53, 434 0 0	53, 434 0 0	125 16 15	0 0 0	69. 00 71. 00 72. 00 73. 00
88. 00 89. 00 90. 00 91. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY	0 0 0	0 0 94, 583 100, 337	94, 583	62	0 177	88. 00 89. 00 90. 00 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES			0	027	0	92. 00 95. 00
97. 00 100. 00	09700 DURABLE MEDICAL EQUIP-SOLD 10000 I&R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0 0 0	O	0 0	0 0 188	0 0	97. 00 100. 00 101. 00
113. 00 118. 00	11300 I NTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0	2, 390, 392	2, 390, 392	9, 236	5, 345	113. 00 118. 00
190. 01 190. 02 190. 03 190. 04	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 SHELBY COUNTY MEDICAL CENTER 19002 SICK CHILD CARE 19003 PRIVATE DUTY 19004 ST. VINCENT'S STRESS	0 0 0 0	0	7, 041 0 0 0	000000000000000000000000000000000000000	0 0	190. 00 190. 01 190. 02 190. 03 190. 04
190. 06 190. 07 190. 08 190. 09	5 19005 MARKETING 19006 MH LIGHTBOUND 19007 I -74 CAMPUS 19008 SOUTHEAST OB 19009 INTELLIPLEX DEVELOPMENT 19010 MMG	0 0 0	3, 634 0 0 0 0	3, 634 0 0 0 0	45 C 29 C	0 0 0	190. 05 190. 06 190. 07 190. 08 190. 09 190. 10
190. 11	19010 MMG 19011 OTHER NON-REIMBURSEABLE CENTERS 19012 BARTLEY ORTHOPEDICS	0 0	· -	0 0	0	0	190. 10 190. 11 190. 12

					5/25/2017 11:	27 am
		CAPI TAL				
		RELATED COSTS				
Cost Center Description	Di rectly	BLDG & FIXT	Subtotal	The state of the s	COMMUNI CATI ONS	
	Assigned New			BENEFI TS		
	Capi tal			DEPARTMENT		
	Related Costs					
	0	1.00	2A	4. 00	5. 01	
190. 13 19013 SSA	0	0	0	0	0	190. 13
190. 14 19014 SPORTSWORKS	0	0	0	0	0	190. 14
190. 15 19015 SHELBY PEDS	0	0	0	0	0	190. 15
190. 16 19016 RENOVO	0	0	0	64	0	190. 16
190. 17 19017 I MA	0	0	0	0	0	190. 17
190. 18 19018 MD SOLUTIONS	0	0	0	97	0	190. 18
190. 19 19019 MHCD	0	4, 997	4, 997	0	0	190. 19
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
192. 01 19201 HOSPI TALI ST	0	0	0	584	10	192. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	48, 285	48, 285	165	156	194. 00
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	2, 454, 349	2, 454, 349	10, 221	5, 511	202. 00

Provider CCN: 15-0097

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2016 Part II
To 12/31/2016 Date/Time Prepared: 5/25/2017 11: 27 am

			'		5/25/2017 11:	
Cost Center Description	DATA	PURCHASI NG,	ADMITTING	CASHI ERI NG/ACC		
	PROCESSI NG	RECEIVING, AND STORES		OUNTS RECEI VABLE	ADMINISTRATIVE AND GENERAL	
	5. 02	5. 03	5. 04	5. 05	5. 06	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FLXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 01160 COMMUNI CATLONS						4. 00 5. 01
5. 02 00550 DATA PROCESSI NG	13, 382					5. 02
5. 03 00590 PURCHASING, RECEIVING, AND STORES	68					5. 03
5. 04 00570 ADMI TTI NG	676					5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	383			586		5. 05
5. 06 00592 OTHER ADMINISTRATIVE AND GENERAL	1, 126		0	0	203, 999	5. 06
7.00 O0700 OPERATION OF PLANT	338		0	0	7, 672	7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	23 608		l ~	0	647 4, 595	8. 00 9. 00
10. 00 01000 DI ETARY	428			o	1, 166	10.00
11. 00 01100 CAFETERI A	0	0	0	0	1, 646	11.00
13.00 O1300 NURSING ADMINISTRATION	315		0	0	2, 451	13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	68		0	0	254	14.00
15. 00 01500 PHARMACY	248		0	0	21, 270	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	383	109	0	0	3, 930	16. 00
30. 00 03000 ADULTS & PEDIATRICS	2, 071	1, 231	1, 882	36	24, 192	30.00
31. 00 03100 INTENSIVE CARE UNIT	428		427	8	5, 418	
41. 00 04100 SUBPROVI DER - RF	0	0	0	0	0	41.00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42. 00
ANCILLARY SERVICE COST CENTERS	04/	2 (0)	4 4/2	0./	15.050	
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	946		4, 463 0	86	15, 859 0	50. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	158			11	4, 899	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	766				13, 536	54. 00
56. 00 05600 RADI OI SOTOPE	0		0	0	0	56. 00
56. 01 05601 0NCOLOGY	406	482	1, 154	22	6, 870	56. 01
57. 00 05700 CT SCAN	68		2, 380	46	3, 228	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	90	67	1, 067	1	2, 323	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	901	1, 401 0	4, 020 0	77	14, 825 0	60. 00 60. 01
65. 00 06500 RESPI RATORY THERAPY	248	1	542	10	3, 592	65.00
65. 01 06501 SLEEP LAB	135				2, 078	65. 01
66. 00 06600 PHYSI CAL THERAPY	451	251	764	15	6, 346	1
69. 00 06900 ELECTROCARDI OLOGY	225	266	604	12	2, 386	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	68	0	2, 154	41	5, 194	71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0		0	0	5, 414	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	0	3, 010	58	836	73. 00
OUTPATIENT SERVICE COST CENTERS 88. OO 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	Ö	ł .	0	0	0	89. 00
90. 00 09000 CLINIC	90		14	0	644	1
91. 00 09100 EMERGENCY	811	1, 374	4, 627	61	13, 405	91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS		1				
95. 00 09500 AMBULANCE SERVICES 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	95. 00 97. 00
100.00 10000 I &R SERVICES-NOT APPRVD PRGM		1		0	0	100.00
101.00 10100 HOME HEALTH AGENCY	270		1	5		101.00
SPECIAL PURPOSE COST CENTERS	2,0		201	<u> </u>	1, 202	
113. 00 11300 NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	12, 796	13, 555	30, 891	566	178, 908	118. 00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 01 19001 SHELBY COUNTY MEDICAL CENTER	0		0	0		190. 00 190. 01
190.01 19001 SHELBY COUNTY MEDICAL CENTER	0	1	0	0		190. 01
190. 03 19003 PRI VATE DUTY	0	1	0	0		190. 02
190. 04 19004 ST. VINCENT'S STRESS	Ö	1	0	0		190. 04
190. 05 19005 MARKETI NG	45		Ō	0		190. 05
190. 06 19006 MH LI GHTBOUND	0	0	0	0	0	190. 06
190. 07 19007 I -74 CAMPUS	113		0	0		190. 07
190. 08 19008 SOUTHEAST OB	0	0	0	0		190. 08
190. 09 19009 NTELLI PLEX DEVELOPMENT	0	0	0	0		190. 09
190. 10 19010 MMG 190. 11 19011 OTHER NON-REIMBURSEABLE CENTERS				0		190. 10 190. 11
190. 11 19011 OTHER NON-REIMBURSEABLE CENTERS 190. 12 19012 BARTLEY ORTHOPEDICS		0				190. 11
190. 13 19013 SSA	0		١	n		190. 12
190. 14 19014 SPORTSWORKS	Ö	0	Ö	Ö		190. 14
190. 15 19015 SHELBY PEDS	0	0	0	o		190. 15
<u> </u>						

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared: | 5/25/2017 11: 27 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS MAJOR HOSPITAL Provider CCN: 15-0097

					3/23/201/ 11.	Z / alli
Cost Center Description	DATA	PURCHASI NG,	ADMITTING	CASHI ERI NG/ACC	OTHER	
	PROCESSI NG	RECEIVING, AND		OUNTS	ADMI NI STRATI VE	
		STORES		RECEI VABLE	AND GENERAL	
	5. 02	5. 03	5. 04	5. 05	5. 06	
190. 16 19016 RENOVO	0	7	C	0	3, 701	190. 16
190. 17 19017 I MA	0	0	C	0	0	190. 17
190. 18 19018 MD SOLUTIONS	0	0	C	0	2, 592	190. 18
190. 19 19019 MHCD	0	0	586	11	3, 793	190. 19
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	C	0	0	192. 00
192. 01 19201 HOSPI TALI ST	203	2	305	6	9, 361	192. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	225	445	162	3	3, 129	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	o	C	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	13, 382	14, 012	31, 944	586	203, 999	202. 00

Provider CCN: 15-0097

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared: | 5/25/2017 11: 27 am

	Cook Cooker Decorated an	ODEDATION OF	I ALINDOV 0	HOUSEKEEDING	DI ETADY	5/25/2017 11:	
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		7.00	8. 00	9. 00	10.00	11. 00	
1 00	GENERAL SERVICE COST CENTERS	T					1.00
1. 00 4. 00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5.02	00550 DATA PROCESSING						5. 02
5.03	00590 PURCHASING, RECEIVING, AND STORES						5. 03
5. 04	00570 ADMITTING						5. 04
5.05	OO580 CASHI ERI NG/ACCOUNTS RECEI VABLE OO592 OTHER ADMINI STRATI VE AND GENERAL						5. 05
5. 06 7. 00	00700 OPERATION OF PLANT	222, 431					5. 06 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 188	12, 371				8. 00
9. 00	00900 HOUSEKEEPI NG	550	0	11, 133			9. 00
10.00	01000 DI ETARY	5, 271	0	266	53, 984		10. 00
11. 00	01100 CAFETERI A	8, 348	0	421	0	84, 315	1
13.00	01300 NURSI NG ADMI NI STRATI ON	3, 604	0	182	0	1, 428	1
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	6, 811 3, 100	0	344 156	0	0 2, 432	
16. 00	01600 MEDICAL RECORDS & LIBRARY	4, 717	0	238	0	3, 365	1
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	.,,,,,	<u>_</u>	200	<u> </u>	0,000	
30.00	03000 ADULTS & PEDIATRICS	51, 976	4, 282	2, 619	48, 295	18, 761	30. 00
31. 00	03100 INTENSIVE CARE UNIT	15, 915	660	803	5, 689	3, 883	1
41. 00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
42. 00	04200 SUBPROVI DER ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	42. 00
50. 00	05000 OPERATING ROOM	20, 850	2. 060	1, 052	0	9, 391	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	1, 008	0	51	0	1, 439	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	19, 897	1, 451	1, 004	0	6, 445	1
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
56. 01	05601 ONCOLOGY	35, 581	340 0	1, 795	0	3, 535	1
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	856 0	0	43 0	0	1, 038 999	
59. 00	05900 CARDI AC CATHETERI ZATI ON	l ő	0	Ö	0	0	59.00
60.00	06000 LABORATORY	4, 293	0	217	0	7, 697	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00	06500 RESPI RATORY THERAPY	1, 790	124	90	0	2, 410	1
65. 01	06501 SLEEP LAB	1 240	0	0	0	4 200	65. 01
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	1, 349 6, 044	469 0	68 305	0	4, 288 1, 857	66. 00 69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0,044	0	0	0	430	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	395	•
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS		_	_1	_		
88. 00 89. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	10, 699	0 43	0 540	0	919	89. 00 90. 00
91. 00	09100 EMERGENCY	11, 350	2, 942	573	0	8, 202	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,	_,			-,	92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	
	10000 &R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	0	0	0	0		100. 00 101. 00
101.00	SPECIAL PURPOSE COST CENTERS	١	U	U	U	0	1101.00
113.00	11300 I NTEREST EXPENSE						113. 00
118.00		215, 197	12, 371	10, 767	53, 984	78, 914	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	796	0	40	0		190.00
	19001 SHELBY COUNTY MEDICAL CENTER 19002 SICK CHILD CARE	0	0	0	0		190. 01 190. 02
	19002 STCK CHIED CARE		0	0	0		190. 02
	19004 ST. VINCENT'S STRESS	o o	0	0	0		190. 04
	19005 MARKETI NG	411	0	21	0		190. 05
190.06	19006 MH LI GHTBOUND	0	0	0	0		190. 06
	19007 I -74 CAMPUS	0	0	0	0		190. 07
	19008 SOUTHEAST OB	0	0	0	0		190. 08
	19009 INTELLIPLEX DEVELOPMENT 19010 MMG		0	0	0		190. 09 190. 10
	19010 MMG 19011 OTHER NON-REIMBURSEABLE CENTERS		0	0	0		190. 10
	19012 BARTLEY ORTHOPEDICS		0	0	0		190. 11
	19013 SSA		Ō	0	0		190. 13
	19014 SPORTSWORKS	0	0	0	0		190. 14
190. 15	19015 SHELBY PEDS	0	0	0	0		190. 15
190. 16	19016 RENOVO	0	0	0	0	1, 679	190. 16

Health Financial Systems MAJOR HOSPITAL In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0097
From 01/01/2016
To 12/31/2016
Date/Time Prepared:
Date/Time

					5/25/2017 11:	27 am
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE				
	7. 00	8. 00	9. 00	10.00	11. 00	
190. 17 19017 I MA	0	0	0	0	0	190. 17
190. 18 19018 MD SOLUTIONS	0	0	0	0	0	190. 18
190. 19 19019 MHCD	565	0	29	0	0	190. 19
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
192. 01 19201 HOSPI TALI ST	0	0	0	0	2, 373	192. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	5, 462	0	276	0	0	194. 00
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)	222, 431	12, 371	11, 133	53, 984	84, 315	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0097

			10) 12/31/2010	Date/lime Pre 5/25/2017 11:	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Subtotal	
	ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY		
	13. 00	14. 00	15. 00	16. 00	24. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 01160 COMMUNI CATI ONS						5. 01
5. 02 00550 DATA PROCESSING						5. 02
5.03 00590 PURCHASING, RECEIVING, AND STORES						5. 03
5. 04 00570 ADMITTI NG 5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 04 5. 05
5. 06 00592 OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11. 00
13.00 01300 NURSING ADMINISTRATION	40, 591					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	68, 313				14. 00
15. 00 01500 PHARMACY	0	o	55, 105			15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	54, 796		16. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	12, 420	0	0	3, 548	632, 878	30. 00
31. 00 03100 I NTENSI VE CARE UNI T	2, 571	0	0	683	178, 484	ı
41. 00 04100 SUBPROVI DER - RF	0	0	0	0	0	41.00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	4 217	٥	0	7 044	250 042	50.00
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 217	0	0	7, 946	258, 063 0	52.00
53. 00 05300 ANESTHESI OLOGY	953	0	0	284	19, 739	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	753	0	0	4, 524	227, 215	1
56. 00 05600 RADI OI SOTOPE		0	0	7, 327	0	56.00
56. 01 05601 0NC0L0GY	2, 340	0	0	2, 076	369, 925	1
57. 00 05700 CT SCAN	2,310	Ö	0	4, 280	19, 750	1
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	o	0	1, 918	6, 568	
59. 00 05900 CARDI AC CATHETERI ZATI ON	o	o	0	0	0	59. 00
60. 00 06000 LABORATORY	O	o	0	7, 228	79, 266	60.00
60. 01 06001 BL00D LABORATORY	0	О	0	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	1, 595	o	0	975	27, 967	65. 00
65. 01 06501 SLEEP LAB	877	0	0	820	4, 649	65. 01
66. 00 06600 PHYSI CAL THERAPY	0	0	0	1, 374	27, 922	66. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 229	0	0	1, 087	67, 574	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	34, 840	0	1, 973	44, 716	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	33, 473	0	1, 901	41, 198	
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	0	55, 105	5, 413	64, 422	73. 00
OUTPATIENT SERVICE COST CENTERS		ما	0	ما	0	00 00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	U	0	O O	0	88. 00 89. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	609	0	0	26	108, 456	
91. 00 09100 EMERGENCY	5, 430	0	0	8, 319	158, 278	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 430	ĭ	O	0, 317	130, 270	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
95. 00 09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	o	0	0	0	97. 00
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100. 00
101.00 10100 HOME HEALTH AGENCY	1, 639	0	0	421	7, 252	101. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	35, 880	68, 313	55, 105	54, 796	2, 344, 322	118. 00
NONREI MBURSABLE COST CENTERS		ام		-	7.005	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
190. 01 19001 SHELBY COUNTY MEDICAL CENTER	0	0	0	0		190. 01 190. 02
190. 02 19002 SI CK CHI LD CARE 190. 03 19003 PRI VATE DUTY		0	0	0		190. 02
190. 04 19004 ST. VINCENT'S STRESS		0	0	0		190. 03
190. 05 19005 MARKETI NG		0	0	0		190. 04
190. 06 19006 MH LI GHTBOUND		0	0	0		190.06
190. 07 19007 I -74 CAMPUS	497	ol Ol	0	0		190.00
190. 08 19008 SOUTHEAST OB	1 0	n N	n	ol n	· ·	190. 08
190. 09 19009 I NTELLI PLEX DEVELOPMENT	7	ol	n	o		190. 09
190. 10 19010 MMG		ol	Ö	ol		190. 10
190. 11 19011 OTHER NON-REIMBURSEABLE CENTERS		o	0	o		190. 11
190. 12 19012 BARTLEY ORTHOPEDICS	0	o	0	o		190. 12
190. 13 19013 SSA	0	o	0	0		190. 13
190. 14 19014 SPORTSWORKS	0	o	0	O		190. 14
190. 15 19015 SHELBY PEDS	0	0	0	0	0	190. 15

Health Financial Systems MAJOR HOSPITAL In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0097
From 01/01/2016
From 01/01/2016
To 12/31/2016
Part II
To 12/31/2016
Part II
To 12/31/2016
Part II
To 12/31/2016

					5/25/2017 11:	27 am
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Subtotal	
	ADMI NI STRATI ON	SERVICES &		RECORDS &		
		SUPPLY		LI BRARY		
	13.00	14.00	15. 00	16. 00	24.00	
190. 16 19016 RENOVO	1, 111	0	C	0	6, 562	190. 16
190. 17 19017 I MA	0	0	C	0	0	190. 17
190. 18 19018 MD SOLUTIONS	0	0	C	0	2, 689	190. 18
190. 19 19019 MHCD	0	0	C	0	9, 981	190. 19
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	C	0	0	192. 00
192. 01 19201 HOSPI TALI ST	1, 571	0	C	0	14, 415	192. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	1, 525	0	C	0	59, 833	194. 00
200.00 Cross Foot Adjustments					0	200. 00
201.00 Negative Cost Centers	0	0	C	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	40, 591	68, 313	55, 105	54, 796	2, 454, 349	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2016 Part II
To 12/31/2016 Date/Time Prepared: 5/25/2017 11: 27 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0097

				5/25/2017 11:	
	Cost Center Description	Intern &	Total		
		Residents Cost			
		& Post			
		Stepdown			
		Adjustments			
		25. 00	26. 00		
	GENERAL SERVICE COST CENTERS	1			-
1. 00	00100 CAP REL COSTS-BLDG & FIXT				1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5. 01	01160 COMMUNI CATI ONS				5. 01
5. 02	00550 DATA PROCESSING				5. 02
5. 03	00590 PURCHASING, RECEIVING, AND STORES				5. 03
5.04	00570 ADMI TTI NG				5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE				5. 05
5.06	00592 OTHER ADMINISTRATIVE AND GENERAL				5. 06
7.00	00700 OPERATION OF PLANT				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE				8. 00
9.00	00900 HOUSEKEEPI NG				9. 00
10.00	01000 DI ETARY				10.00
11. 00	01100 CAFETERI A				11. 00
13.00	01300 NURSING ADMINISTRATION				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY				14.00
15. 00	01500 PHARMACY				15. 00
16. 00	1 1				16.00
	I NPATIENT ROUTINE SERVICE COST CENTERS	•			
30.00		0	632, 878		30.00
31. 00	+ I	0	178, 484		31. 00
41. 00	1 1	0	0		41. 00
42. 00	1 1	0	o		42. 00
	ANCILLARY SERVICE COST CENTERS		-1		1
50.00		0	258, 063		50.00
52. 00		o	0		52. 00
53. 00	+ I	0	19, 739		53. 00
54.00	+ I	o	227, 215		54.00
56. 00	+ I	o	0		56. 00
56. 01	05601 ONCOLOGY	o	369, 925		56. 01
57. 00	1 1	o	19, 750		57. 00
58. 00	+ I	o	6, 568		58. 00
59. 00	1 1	0	0, 555		59. 00
60. 00	06000 LABORATORY	0	79, 266		60.00
60. 01	06001 BLOOD LABORATORY	0	77,200		60. 01
65. 00	06500 RESPI RATORY THERAPY		27, 967		65. 00
65. 01	06501 SLEEP LAB		4, 649		65. 01
66. 00		0	27, 922		66. 00
69. 00	1	0	67, 574		69.00
71. 00		0	44, 716		71.00
72. 00	1		41, 198		72.00
73. 00	1 I	0	64, 422		73.00
73.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	04, 422		73.00
88. 00		0	0		88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	o		89. 00
	09000 CLINIC	0	108, 456		90.00
91. 00		0	158, 278		91.00
92. 00	· · · · · · · · · · · · · · · · · · ·	0	100, 270		92. 00
72.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>			1 /2.00
95. 00		0	0		95. 00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97. 00
	10000 I &R SERVI CES-NOT APPRVD PRGM	o	0		100.00
	0 10100 HOME HEALTH AGENCY	o	7, 252		101.00
. 3 1 . 0	SPECIAL PURPOSE COST CENTERS	<u> </u>	7, 202		1.555
113. 0	11300 NTEREST EXPENSE				113. 00
118. 0		o	2, 344, 322		118.00
	NONREI MBURSABLE COST CENTERS				
190. 0	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7, 895		190. 00
190.0	1 19001 SHELBY COUNTY MEDICAL CENTER	0	o		190. 01
190. 0	2 19002 SICK CHILD CARE	o	ol		190. 02
	3 19003 PRI VATE DUTY		ol		190. 03
	4 19004 ST. VINCENT'S STRESS	0	o		190. 04
	5 19005 MARKETI NG	0	5, 285		190. 05
	6 19006 MH LI GHTBOUND		587		190. 06
	7 19007 I -74 CAMPUS	0	2, 581		190. 07
	B 19008 SOUTHEAST OB		0		190. 08
	9 19009 I NTELLI PLEX DEVELOPMENT		199		190. 09
	19010 MMG		,		190. 10
	1 19011 OTHER NON-REIMBURSEABLE CENTERS		Ö		190. 11
	2 19012 BARTLEY ORTHOPEDICS		o		190. 12
	3 19013 SSA	0	o		190. 12
	i I	, 9	٩		

Health Financial Systems	MAJOR HOS	In Lieu of Form CMS-2552-10					
ALLOCATION OF CAPITAL RELATED COSTS		Provider Co	CN: 15-0097	Period: From 01/01 To 12/31		Worksheet B Part II Date/Time Pr 5/25/2017 11	epared: : 27 am
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total					
	25. 00	26. 00					

	Residents Cost & Post Stepdown Adjustments			
	25. 00	26.00		
190. 14 19014 SPORTSWORKS	0	0	190	0. 14
190. 15 19015 SHELBY PEDS	0	0	190	D. 15
190. 16 19016 RENOVO	0	6, 562	190	0. 16
190. 17 19017 I MA	0	0	190	0. 17
190. 18 19018 MD SOLUTIONS	0	2, 689	190). 18
190. 19 19019 MHCD	0	9, 981	190). 19
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	192	2. 00
192. 01 19201 HOSPI TALI ST	0	14, 415	192	2. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	59, 833	194	1. 00
200.00 Cross Foot Adjustments	0	0	200	0. 00
201.00 Negative Cost Centers	0	0	201	1. 00
202.00 TOTAL (sum lines 118-201)	0	2, 454, 349	202	2. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0097 Peri od: Worksheet B-1 From 01/01/2016 12/31/2016 Date/Time Prepared: 5/25/2017 11:27 am CAPI TAL RELATED COSTS Cost Center Description **EMPLOYEE** COMMUNICATIONS DATA PURCHASI NG, BLDG & FIXT PROCESSI NG (SOUARE FEET) BENEFITS RECEIVING. AND DEPARTMENT (TELEPHONES) (HARDWARE) **STORES** (GROSS (PURCHASING) SALARIES) 1.00 5. 01 5. 02 5. 03 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 129, 668 1 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 540 43, 935, 172 4 00 5.01 01160 COMMUNI CATI ONS 291 15,000 530 5.01 00550 DATA PROCESSING 5 02 678 1, 241, 960 594 5 02 25 5.03 00590 PURCHASING, RECEIVING, AND STORES 729 271, 014 8 2, 245, 441 5.03 1, 123, 981 5.04 00570 ADMITTING 1,618 22 30 24, 318 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 459, 580 17 15, 353 5.05 0 00592 OTHER ADMINISTRATIVE AND GENERAL 10,613 5.472.487 50 5 06 41 46, 439 5 06 7.00 00700 OPERATION OF PLANT 11, 314 1,024,732 0 15 4,888 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 555 31, 526 0 158 8.00 00900 HOUSEKEEPI NG 898, 930 27 9.00 257 42, 456 9.00 168, 450 10.00 01000 DI ETARY 2.462 10 19 17, 447 10.00 11.00 01100 CAFETERI A 3,899 427, 675 0 0 0 11.00 01300 NURSING ADMINISTRATION 13.00 1,683 546, 074 37 14 39, 017 13.00 01400 CENTRAL SERVICES & SUPPLY 3, 181 3 91, 925 14.00 14.00 5 9 15 00 01500 PHARMACY 1.448 1, 032, 069 11 25, 147 15 00 01600 MEDICAL RECORDS & LIBRARY 2, 203 17, 402 16.00 813, 832 16 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDLATRICS 24, 273 5, 811, 156 76 92 197, 250 30.00 19 31.00 03100 INTENSIVE CARE UNIT 7,433 1, 137, 807 19 135, 417 31.00 04100 SUBPROVIDER - IRF 41.00 41.00 0 0 0 04200 SUBPROVI DER 42.00 42.00 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 9,738 3, 250, 699 49 42 578, 356 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 0 52.00 53.00 05300 ANESTHESI OLOGY 471 2, 643, 264 0 132, 629 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 9, 293 2, 294, 834 24 34 55, 418 54.00 05600 RADI OI SOTOPE 56, 00 56,00 56.01 05601 ONCOLOGY 16, 618 1, 154, 888 49 18 77, 182 56.01 05700 CT SCAN 368, 399 57 00 400 0 3 24.639 57 00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 355, 671 0 4 10, 706 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 C 0 59.00 06000 LABORATORY 2,005 1, 830, 790 40 60.00 22 224, 453 60.00 06001 BLOOD LABORATORY 0 60.01 0 Λ 60.01 65.00 06500 RESPIRATORY THERAPY 836 853, 195 32 11 37, 688 65.00 65.01 06501 SLEEP LAB 443, 278 20, 743 65.01 6 06600 PHYSI CAL THERAPY 1, 597, 842 20 66 00 630 24 40 244 66 00 69.00 06900 ELECTROCARDI OLOGY 2,823 536, 670 0 10 42, 620 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 68, 542 0 3 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 66, 018 0 72.00 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 0 0 4, 997 7, 997 90.00 09000 CLI NI C 17 265, 400 4 90 00 91.00 09100 EMERGENCY 5, 301 2, 700, 388 21 36 220, 257 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 0 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 97.00 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 0 100 00 101.00 10100 HOME HEALTH AGENCY 804, 878 0 42, 153 101. 00 0 12 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 126, 289 39, 711, 029 514 568 2, 172, 302 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 372 0 190. 00 C 0 190. 01 19001 SHELBY COUNTY MEDICAL CENTER 0 190. 01 0 0 0 190. 02 19002 SICK CHILD CARE 0 0 0 190. 02 0 0 190. 03 19003 PRI VATE DUTY 0 r 0 190.03 190. 04 19004 ST. VINCENT'S STRESS 0 0 190.04 0 2 0 5 0 190. 05 19005 MARKETI NG 192 194, 596 0 190. 05 190. 06 19006 MH LI GHTBOUND 0 0 190, 06 0 0 190. 07 19007 I - 74 CAMPUS 0 123, 913 437 190. 07 0 190.08 190. 08 19008 SOUTHEAST OB 0 0 0 190. 09 19009 INTELLIPLEX DEVELOPMENT 2, 174 0 0 190.09 190. 10 19010 MMG 0 0 190. 10 C 190. 11 19011 OTHER NON-REIMBURSEABLE CENTERS 0 0 0 190. 11

				''	0 12/31/2010	5/25/2017 11:	
	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNI CATI ONS (TELEPHONES)		PURCHASI NG, RECEI VI NG, AND STORES (PURCHASI NG)	
		1.00	4.00	5. 01	5. 02	5. 03	
190. 12 19012	BARTLEY ORTHOPEDICS	0	0	0	0	0	190. 12
190. 13 19013	SSA	0	0	0	0	0	190. 13
190. 14 19014	SPORTSWORKS	0	0	0	0	0	190. 14
190. 15 19015	SHELBY PEDS	0	0	0	0	0	190. 15
190. 16 19016	RENOVO	0	274, 385	0	0	1, 167	190. 16
190. 17 19017	' I MA	0	0	0	0	0	190. 17
190. 18 19018	MD SOLUTIONS	0	414, 583	0	0		190. 18
190. 19 19019	MHCD	264	0	0	0		190. 19
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
192. 01 19201	HOSPI TALI ST	0	2, 504, 424	1	9	285	192. 01
	OTHER NONREIMBURSABLE COST CENTERS	2, 551	710, 068	15	10	71, 250	194. 00
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)	2, 454, 349	10, 620, 548	21, 483	3, 838, 026	454, 165	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	18. 927947	0. 241732	40. 533962	6, 461. 323232	0. 202261	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)		10, 221	5, 511	13, 382	14, 012	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part		0. 000233	10. 398113	22. 528620	0. 006240	205. 00

In Lieu of Form CMS-2552-10 Health Financial Systems MAJOR HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0097 Peri od: Worksheet B-1 From 01/01/2016 12/31/2016 Date/Time Prepared: 5/25/2017 11:27 am Cost Center Description ADMI TTI NG CASHIERING/ACC Reconciliation OTHER OPERATION OF ADMI NI STRATI VE (GROSS OUNTS PLANT CHARGES) RECEI VABLE AND GENERAL (SQUARE (GROSS (ACCUM. FEET) CHARGES) COST) 5.04 5A. 06 5.06 7.00 5.05 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.01 01160 COMMUNI CATI ONS 5.01 00550 DATA PROCESSING 5.02 5.02 00590 PURCHASING, RECEIVING, AND STORES 5.03 5.03 00570 ADMITTING 5.04 306, 844, 615 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 306, 844, 615 5.05 5.06 00592 OTHER ADMINISTRATIVE AND GENERAL -10, 275, 932 79, 144, 630 5.06 0 00700 OPERATION OF PLANT 2, 975, 979 103, 885 7 00 0 Ω 0 7 00 00800 LAUNDRY & LINEN SERVICE 0 8.00 C 0 251,000 555 8.00 9.00 00900 HOUSEKEEPI NG 0 1, 782, 331 257 9.00 10.00 01000 DI ETARY 0 0 0 452, 169 2, 462 10.00 01100 CAFFTERIA 0 11 00 638 557 3 899 11 00 0 01300 NURSING ADMINISTRATION 13.00 0 950, 834 1, 683 13.00 01400 CENTRAL SERVICES & SUPPLY 0 0 14.00 0 98, 390 3, 181 14.00 01500 PHARMACY 0 15 00 8 250 615 15 00 1 448 0 16.00 01600 MEDICAL RECORDS & LIBRARY 1, 524, 523 2, 203 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 18, 094, 161 18, 094, 161 0 9, 398, 346 24, 273 30.00 0 03100 INTENSIVE CARE UNIT 4, 107, 091 4, 107, 091 2, 101, 791 31.00 7.433 31.00 41.00 04100 SUBPROVIDER - IRF 0 0 41.00 04200 SUBPROVI DER 0 42.00 0 42.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 42, 913, 547 42, 913, 547 0 9.738 50 00 6, 151, 826 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 05300 ANESTHESI OLOGY 5, 552, 571 5, 552, 571 0 1, 900, 127 53.00 471 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 24, 190, 293 24, 190, 293 5, 250, 583 9. 293 54.00 0 05600 RADI OI SOTOPE 56.00 0 56.00 05601 ONCOLOGY 11, 100, 753 11, 100, 753 0 2, 664, 760 16, 618 56.01 56.01 22, 885, 756 57.00 05700 CT SCAN 22, 885, 756 1, 252, 173 400 57 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 10, 256, 555 10, 256, 555 0 901, 000 58.00 58.00 0 05900 CARDIAC CATHETERIZATION 0 59 00 Λ 59 00 06000 LABORATORY 5, 750, 503 60.00 38, 652, 651 38, 652, 651 2,005 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 1, 393, 183 06500 RESPIRATORY THERAPY 0 65.00 5, 214, 797 5, 214, 797 836 65, 00 0 65.01 06501 SLEEP LAB 4, 385, 681 4, 385, 681 806, 022 Λ 65.01 66,00 06600 PHYSI CAL THERAPY 7, 348, 316 7, 348, 316 0 2, 461, 479 630 66.00 06900 ELECTROCARDI OLOGY 0 925, 552 2,823 69.00 5, 811, 638 5, 811, 638 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 20, 716, 080 0 2, 014, 904 71.00 20, 716, 080 Ω 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 2, 100, 061 0 72.00 07300 DRUGS CHARGED TO PATIENTS 28, 946, 031 28, 946, 031 324, 195 73.00 73.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 90.00 09000 CLI NI C 137,073 137, 073 0 249, 857 4, 997 90.00 09100 EMERGENCY 0 91 00 44, 153, 535 44, 153, 535 5, 199, 587 5, 301 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00 0 0 0 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 Λ 97.00 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 2, 250, 052 2, 250, 052 0 1, 641, 450 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 296, 716, 581 296, 716, 581 -10, 275, 932 69, 411, 797 100, 506 118. 00 NONREIMBURSABLE COST CENTERS 372 190, 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 7 041 190. 01 19001 SHELBY COUNTY MEDICAL CENTER 0 0 0 0 190, 01 190. 02 19002 SICK CHILD CARE 0 0 0 0 190. 02 0 190. 03 19003 PRI VATE DUTY 0 0 0 0 0 0 0 190. 03 190. 04 19004 ST. VINCENT'S STRESS 0 0 190 04 Ω 190. 05 19005 MARKETI NG 0 0 437, 887 192 190.05 190. 06 19006 MH LI GHTBOUND 0 190.06 190. 07 19007 I - 74 CAMPUS 0 0 0 0 460, 773 0 190. 07 190. 08 19008 SOUTHEAST OB C 0 0 190, 08 190. 09 19009 INTELLIPLEX DEVELOPMENT 0 190. 09 69, 981 0 190. 10 19010 MMG 0 0 0 190. 10 0 190. 11 19011 OTHER NON-REIMBURSEABLE CENTERS

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190. 13 19013 SSA

190. 12 19012 BARTLEY ORTHOPEDICS

			'	0 12/31/2010	5/25/2017 11:	
Cost Center Description	ADMI TTI NG	CASHI ERI NG/ACC	Reconciliation	OTHER	OPERATION OF	
	(GROSS	OUNTS		ADMI NI STRATI VE	PLANT	
	CHARGES)	RECEI VABLE		AND GENERAL	(SQUARE	
		(GROSS		(ACCUM.	FEET)	
		CHARGES)		COST)		
	5. 04	5. 05	5A. 06	5. 06	7. 00	
190. 14 19014 SPORTSWORKS	0	0	0	0	0	190. 14
190. 15 19015 SHELBY PEDS	0	0	0	0		190. 15
190. 16 19016 RENOVO	0	0	0	1, 435, 784	0	190. 16
190. 17 19017 I MA	0	0	0	0	0	190. 17
190. 18 19018 MD SOLUTIONS	0	0	0	1, 005, 296	0	190. 18
190. 19 19019 MHCD	5, 636, 411	5, 636, 411	0	1, 471, 226	264	190. 19
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
192. 01 19201 HOSPI TALI ST	2, 931, 171	2, 931, 171	0	3, 631, 129	0	192. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	1, 560, 452	1, 560, 452	0	1, 213, 716	2, 551	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	1, 737, 377	1, 699, 202		10, 275, 932	3, 362, 371	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 005662	0. 005538		0. 129837	32. 366280	203. 00
204.00 Cost to be allocated (per Wkst. B,	31, 944	586		203, 999	222, 431	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 000104	0. 000002		0. 002578	2. 141127	205. 00
)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0097

				10) 12/31/2010	Date/lime Pre 5/25/2017 11:	
	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (PATI ENT DAYS)	CAFETERI A (MANHOURS)	NURSI NG ADMI NI STRATI ON	- , a
		LAUNDRY) 8.00	9. 00	10.00	11. 00	(MANHOURS) 13.00	
	GENERAL SERVICE COST CENTERS	8.00	9.00	10.00	11.00	13.00	
1. 00 4. 00 5. 01 5. 02	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNICATIONS 00550 DATA PROCESSING						1.00 4.00 5.01 5.02
5. 03 5. 04 5. 05 5. 06 7. 00 8. 00	00590 PURCHASING, RECEIVING, AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00592 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	426, 482	400,070				5. 03 5. 04 5. 05 5. 06 7. 00 8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	103, 073 2, 462	10, 419			9.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0	3, 899 1, 683	0	896, 595 15, 188	652, 022	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	o	3, 181	Ö	0	0	14. 00
15.00	01500 PHARMACY	0	1, 448		25, 863	0	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY I NPATIENT ROUTINE SERVICE COST CENTERS	0	2, 203	0	35, 781	0	16. 00
30. 00	03000 ADULTS & PEDIATRICS	147, 667	24, 273	9, 321	199, 506	199, 506	30. 00
31.00	03100 NTENSIVE CARE UNIT	22, 749	7, 433		41, 294	41, 294	31.00
41. 00 42. 00	04100 SUBPROVI DER	0	0	0	0	0	41. 00 42. 00
12.00	ANCILLARY SERVICE COST CENTERS	3		5	<u> </u>		12.00
50.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	71, 015	9, 738	0	99, 868	99, 868	50.00
52. 00 53. 00	05300 ANESTHESI OLOGY	0	0 471	0	15, 305	0 15, 305	52. 00 53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	50, 007	9, 293	Ö	68, 534	0	54. 00
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
56. 01 57. 00	05601	11, 708	16, 618 400	0	37, 593 11, 038	37, 593 0	56. 01 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	O	0	Ö	10, 624	Ö	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00 60. 01	O6000 LABORATORY O6001 BLOOD LABORATORY	8	2, 005	0	81, 853	0	60. 00 60. 01
65. 00	06500 RESPIRATORY THERAPY	4, 261	836	0	25, 627	25, 627	65. 00
65. 01	06501 SLEEP LAB	0	0	0	0	14, 089	65. 01
66. 00	06600 PHYSI CAL THERAPY	16, 157	630	0	45, 594	0	66.00
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	2, 823 0	0	19, 749 4, 568	19, 749 0	69. 00 71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	O	0	Ö	4, 200	Ö	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	l ol	0	O	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89. 00
	09000 CLI NI C	1, 477	4, 997		9, 775		
	09100 EMERGENCY	101, 433	5, 301	0	87, 219	87, 219	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
	10000 1&R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	0	0	0	0	0 26, 327	100.00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		<u> </u>		20, 321	101.00
	11300 I NTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	426, 482	99, 694	10, 419	839, 179	576, 352	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	372	0	0	0	190. 00
	19001 SHELBY COUNTY MEDICAL CENTER	0	0	0	0		190. 01
	2 19002 SICK CHILD CARE 3 19003 PRIVATE DUTY	0	0	0	0		190. 02 190. 03
	19004 ST. VINCENT'S STRESS		0		0		190. 03
	19005 MARKETI NG	0	192	0	0		190. 05
	19006 MH LI GHTBOUND	0	0	0	6, 242		190.06
	/ 19007 -74 CAMPUS 19008 SOUTHEAST OB		0	0	7, 981 0		190. 07 190. 08
	19009 INTELLI PLEX DEVELOPMENT		0		114		190.00
190. 10	19010 MMG	0	0	0	0		190. 10
	19011 OTHER NON-REIMBURSEABLE CENTERS 19012 BARTLEY ORTHOPEDICS	0	0	0	0		190. 11 190. 12
	19012 BARTLEY ORTHOPEDICS 19013 SSA	0	0	0	0		190. 12
	19014 SPORTSWORKS	o o	Ö	Ö	0		190. 14
			·	<u> </u>			

					5/25/2017 11:	27 am
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	LINEN SERVICE	(SQUARE	(PATI ENT	(MANHOURS)	ADMI NI STRATI ON	
	(POUNDS OF	FEET)	DAYS)			
	LAUNDRY)				(MANHOURS)	
	8. 00	9. 00	10.00	11. 00	13. 00	
190. 15 19015 SHELBY PEDS	0	0	0	0	0	190. 15
190. 16 19016 RENOVO	0	0	0	17, 849	17, 849	190. 16
190. 17 19017 I MA	0	0	0	0	0	190. 17
190. 18 19018 MD SOLUTIONS	0	0	0	0	0	190. 18
190. 19 19019 MHCD	0	264	0	0	0	190. 19
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192. 00
192. 01 19201 HOSPI TALI ST	0	0	0	25, 230	25, 230	192. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	2, 551	0	0	24, 496	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	301, 552	2, 022, 062	638, 862	924, 151	1, 177, 431	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 707069	19. 617766	61. 317017	1. 030734	1. 805815	203. 00
204.00 Cost to be allocated (per Wkst. B,	12, 371	11, 133	53, 984	84, 315	40, 591	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 029007	0. 108011	5. 181303	0. 094039	0. 062254	205. 00

Provider CCN: 15-0097

				10	o 12/31/2016 Date/lime Pr 5/25/2017 11	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL		
		SERVICES &	(100% DRUGS TO	RECORDS &		
		SUPPLY (100%	PATI ENTS)	LI BRARY (GROSS		
		SUPPLI ES)		CHARGES)		
		14.00	15. 00	16. 00		
	GENERAL SERVICE COST CENTERS	1 T		ı		
1.00	00100 CAP REL COSTS-BLDG & FLXT					1.00
4. 00 5. 01	OO4OO EMPLOYEE BENEFITS DEPARTMENT O1160 COMMUNI CATIONS					4. 00 5. 01
5. 02	00550 DATA PROCESSING					5. 02
5. 03	00590 PURCHASING, RECEIVING, AND STORES					5. 03
5.04	00570 ADMITTING					5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE					5. 05
5. 06	00592 OTHER ADMINISTRATIVE AND GENERAL					5. 06
7.00	00700 OPERATION OF PLANT					7. 00
8. 00 9. 00	O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING					8. 00 9. 00
10. 00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11. 00
13.00	01300 NURSING ADMINISTRATION					13. 00
	01400 CENTRAL SERVICES & SUPPLY	100				14. 00
	01500 PHARMACY	0	100			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	0	292, 682, 177		16. 00
30.00	03000 ADULTS & PEDIATRICS	l	0	18, 972, 176		30.00
	03100 NTENSI VE CARE UNI T	0	O	3, 650, 056		31. 00
41.00	04100 SUBPROVI DER - I RF	O	0	0		41. 00
42.00	04200 SUBPROVI DER	0	0	0		42. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	O	o	42 402 547		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0	42, 492, 567 0		52.00
53. 00	05300 ANESTHESI OLOGY	0	Ö	1, 518, 167		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	o	0	24, 190, 293		54.00
56.00	05600 RADI OI SOTOPE	0	0	0		56. 00
56. 01	05601 ONCOLOGY	0	0	11, 100, 753		56. 01
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	22, 885, 756 10, 256, 555		57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	10, 256, 555		59.00
60. 00	06000 LABORATORY	0	Ö	38, 652, 651		60.00
60. 01	06001 BLOOD LABORATORY	0	0	0		60. 01
65. 00	06500 RESPI RATORY THERAPY	0	0	5, 214, 797		65. 00
65. 01 66. 00	06501 SLEEP LAB 06600 PHYSI CAL THERAPY	0	0	4, 385, 681		65. 01 66. 00
	06900 ELECTROCARDI OLOGY		0	7, 348, 316 5, 811, 638		69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	51	Ö	10, 552, 292		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	49	0	10, 163, 788		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	100	28, 946, 031		73. 00
00.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	O	0	0		- 00 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0		88. 00 89. 00
	09000 CLINIC	0	Ö	137, 073		90.00
	09100 EMERGENCY	o	0	44, 153, 535		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92. 00
05 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES		٥	0		95. 00
	09700 DURABLE MEDICAL EQUIP-SOLD		0	0		97. 00
	10000 I &R SERVICES-NOT APPRVD PRGM	0	Ö	0		100.00
101.00	10100 HOME HEALTH AGENCY	0	0	2, 250, 052		101. 00
440.00	SPECIAL PURPOSE COST CENTERS	1				
113. 00 118. 00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	100	100	202 402 177		113. 00 118. 00
118.00	NONREIMBURSABLE COST CENTERS	100	100]	292, 682, 177		118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	0		190. 00
	19001 SHELBY COUNTY MEDICAL CENTER	O	0	0		190. 01
	19002 SICK CHILD CARE	0	0	0		190. 02
	19003 PRI VATE DUTY	0	0	0		190. 03
	19004 ST. VI NCENT' S STRESS 19005 MARKETI NG	0	0	0		190. 04 190. 05
	19006 MH LIGHTBOUND		0	0		190. 05
	19007 I -74 CAMPUS		0	0		190.00
	19008 SOUTHEAST OB		o	o		190. 08
	19009 I NTELLI PLEX DEVELOPMENT	0	0	0		190. 09
	19010 MMG	0	0	0		190. 10
	19011 OTHER NON-REIMBURSEABLE CENTERS 19012 BARTLEY ORTHOPEDICS	0	0	0		190. 11 190. 12
	19013 SSA	0	0	0		190. 12
	t transfer to the second secon	<u>, </u>	<u> </u>	<u> </u>		

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS MAJOR HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0097

Peri od: From 01/01/2016 To 12/31/2016 Date/Ti me Prepared: 5/25/2017 11: 27 am

					5/25/2017 11: 27 am
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	
		SERVICES &	(100% DRUGS TO	RECORDS &	
		SUPPLY	PATI ENTS)	LI BRARY	
		(100%		(GROSS	
		SUPPLI ES)		CHARGES)	
		14. 00	15. 00	16.00	
190. 14 19014	4 SPORTSWORKS	0	0	C	190. 14
190. 15 19015	SHELBY PEDS	0	0	C	190. 15
190. 16 19016	S RENOVO	0	0		190. 16
190. 17 19017	7 I MA	0	0		190. 17
190. 18 19018	MD SOLUTIONS	0	0	(190. 18
190. 19 19019	MHCD	0	0	(190. 19
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	(192. 00
192. 01 1920°	I HOSPI TALI ST	0	0	(192. 01
194. 00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	C	194. 00
200. 00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201. 00
202.00	Cost to be allocated (per Wkst. B,	276, 526	9, 423, 781	1, 873, 864	202. 00
	Part I)				
203.00	Unit cost multiplier (Wkst. B, Part I)	2, 765. 260000	94, 237. 810000	0. 006402	203. 00
204.00	Cost to be allocated (per Wkst. B,	68, 313	55, 105	54, 796	204. 00
	Part II)				
205.00	Unit cost multiplier (Wkst. B, Part	683. 130000	551. 050000	0. 000187	205. 00
	11)				

				rom 01/01/2016 o 12/31/2016	Part I Date/Time Pre	pared:
		Ti tl o	XVIII	Hospi tal	5/25/2017 11: PPS	27 am
		11110	XVIII	Costs	113	
Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	26)	2.00	2.00	4.00	F 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1. 00	2.00	3. 00	4. 00	5. 00	
30. 00 03000 ADULTS & PEDIATRICS	13, 243, 753	I	13, 243, 753	ار	13, 243, 753	30.00
31. 00 03100 NTENSI VE CARE UNI T	2, 984, 990		2, 984, 990		2, 984, 990	
41. 00 04100 SUBPROVI DER - 1 RF	2, 904, 990		2, 904, 990	1	2, 964, 990	41.00
42. 00 04200 SUBPROVI DER				1	0	
ANCI LLARY SERVI CE COST CENTERS				y U	0	42.00
50. 00 05000 OPERATING ROOM	8, 062, 312		8, 062, 312	ار ار	8, 062, 312	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0,002,312		0,002,312	1	0,002,312	52.00
53. 00 05300 ANESTHESI OLOGY	2, 224, 451		2, 224, 451	1 1	2, 365, 029	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	6, 676, 255		6, 676, 255	1	6, 676, 255	54.00
56. 00 05600 RADI 0I SOTOPE	0,070,233		0,070,230		0, 070, 233	56.00
56. 01 05601 0NCOLOGY	4, 060, 594		4, 060, 594	4, 105	4, 064, 699	56. 01
57. 00 05700 CT SCAN	1, 593, 437		1, 593, 437		1, 593, 437	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 094, 596		1, 094, 596		1, 094, 596	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	1,074,370		1,074,070	1	1,074,370	59.00
60. 00 06000 LABORATORY	6, 933, 188		6, 933, 188	1 1	6, 933, 188	
60. 01 06001 BLOOD LABORATORY	0, 755, 100		0, 755, 100		0, 755, 100	60. 01
65. 00 06500 RESPIRATORY THERAPY	1, 726, 619	0	1, 726, 619		1, 726, 619	65. 00
65. 01 06501 SLEEP LAB	964, 192		964, 192		964, 192	
66. 00 06600 PHYSI CAL THERAPY	2, 919, 283	0	2, 919, 283		2, 921, 021	66. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 285, 699		1, 285, 699		1, 285, 699	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 489, 805		2, 489, 805		2, 489, 805	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	2, 577, 623		2, 577, 623		2, 577, 623	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	9, 975, 381		9, 975, 381	I	9, 975, 381	
OUTPATIENT SERVICE COST CENTERS	7,770,001		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	<u> </u>	77 77 00 1	70.00
88. 00 08800 RURAL HEALTH CLINIC	0		(ol	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			ol	0	89. 00
90. 00 09000 CLI NI C	571, 711		571, 711	50, 949	622, 660	90.00
91. 00 09100 EMERGENCY	6, 752, 159		6, 752, 159		7, 112, 682	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 421, 787		1, 421, 787	1	1, 421, 787	1
OTHER REIMBURSABLE COST CENTERS			<u> </u>	'		
95. 00 09500 AMBULANCE SERVICES	0		C	0	0	95. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0			o	0	97. 00
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0				0	100.00
101.00 10100 HOME HEALTH AGENCY	1, 916, 518		1, 916, 518	3	1, 916, 518	101. 00
SPECIAL PURPOSE COST CENTERS				, , , , , , , , , , , , , , , , , , ,		1
113. 00 11300 NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	79, 474, 353	0	79, 474, 353	557, 893	80, 032, 246	200. 00
201.00 Less Observation Beds	1, 421, 787		1, 421, 787	·	1, 421, 787	
202.00 Total (see instructions)	78, 052, 566	0	78, 052, 566	557, 893	78, 610, 459	202. 00

					To 12/31/2016	Date/Time Pre 5/25/2017 11:	
			Title	XVIII	Hospi tal	PPS	
	·		Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·		·	+ col. 7)	Ratio	Inpati ent	
						Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	15, 840, 443		15, 840, 44	3		30. 00
31.00	03100 INTENSIVE CARE UNIT	3, 650, 056		3, 650, 05	5		31.00
41.00	04100 SUBPROVI DER - I RF	0)		41.00
42.00	04200 SUBPROVI DER	0			O		42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	10, 113, 287	32, 379, 280	42, 492, 56	0. 189735	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0.000000	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	293, 327	1, 224, 840	1, 518, 16	7 1. 465222	0.000000	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 370, 394	21, 819, 899	24, 190, 29	0. 275989	0.000000	54.00
56.00	05600 RADI OI SOTOPE	0	0		0. 000000	0.000000	56.00
56. 01	05601 ONCOLOGY	44, 569	11, 056, 184	11, 100, 75	0. 365794	0.000000	56. 01
57.00	05700 CT SCAN	3, 386, 668	19, 499, 088	22, 885, 75	0. 069626	0.000000	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	765, 516	9, 491, 039	10, 256, 55	0. 106722	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0. 000000	0.000000	59. 00
60.00	06000 LABORATORY	7, 657, 119	30, 995, 532	38, 652, 65	0. 179372	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0. 000000	0.000000	60. 01
65.00	06500 RESPI RATORY THERAPY	4, 387, 690	827, 107	5, 214, 79	0. 331100	0.000000	65. 00
65. 01	06501 SLEEP LAB	5, 308	4, 380, 373	4, 385, 68	0. 219850	0.000000	65. 01
66.00	06600 PHYSI CAL THERAPY	1, 192, 586	6, 155, 730	7, 348, 31	0. 397272	0.000000	66. 00
69.00	06900 ELECTROCARDI OLOGY	731, 429	5, 080, 209	5, 811, 63	0. 221228	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 616, 800	7, 935, 492	10, 552, 29	0. 235949	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	5, 282, 334	4, 881, 454	10, 163, 78	0. 253608	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	8, 397, 808	20, 548, 223	28, 946, 03	0. 344620	0.000000	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0)		88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		o		89. 00
90.00	09000 CLI NI C	202	136, 871	137, 07	4. 170851	0.000000	90.00
91.00	09100 EMERGENCY	6, 433, 310	37, 720, 225	44, 153, 53	0. 152925	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	O	3, 131, 733	3, 131, 73	0. 453994	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0		0.000000	0.000000	95. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	o	0		0. 000000	0.000000	97. 00
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	o	0		o i		100.00
101.00	10100 HOME HEALTH AGENCY	0	2, 250, 052	2, 250, 05	2		101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	73, 168, 846	219, 513, 331	292, 682, 17	7		200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	73, 168, 846	219, 513, 331	292, 682, 17	7		202. 00
		·			·		

Health Financial Systems	MAJOR HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0097	Peri od: From 01/01/2016	Worksheet C Part I
		To 12/31/2016	Date/Time Prepared:

Title XVIII Hospital PPS Inpatient Ratio 11.00				To 12/31/2016	Date/Time Prepared: 5/25/2017 11:27 am
INPATI ENT ROUTINE SERVICE COST CENTERS 10,00 30,00 3000 ADULT'S & PEDIATRICS 30,00 31,00 3010 INTENSIVE CARE UNIT 31,00 41,00 410,0			Title XVIII	Hospi tal	
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDI ATRIC S 31.00 41.00 04100 MIRDINE WE CARE UNIT 31.00 42.00 04200 04200 SUBPROVI DER 18F 42.00 42.00 04200 SUBPROVI DER 42.00 42.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 52.00 52.00 05300 DELI VERY ROOM & LABOR ROOM 0.000000 52.00 53.00 05300 ARESTHESI OLORY 1.557819 53.00 54.00 05400 RADI OLORY-DI AGNOSTI C 0.275989 54.00 56.00 05600 RADI OLORY-DI AGNOSTI C 0.275989 54.00 56.00 05600 RADI OLORY-DI AGNOSTI C 0.275989 54.00 56.00 05600 RADI OLORY-DI AGNOSTI C 0.000000 56.00 57.00 05700 05700 C7 SCAN 0.06664 56.01 58.00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 0.06626 57.00 59.00 05900 CARDI AG CATHETERI ZATI ON 0.000000 0.5900 CARDI AG CATHETERI ZATI ON 0.000000 0.00000 0.0000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.00000000	Cost Center Description				
IMPATI ENT ROUTINE SERVICE COST CENTERS 30 .00 330					
30.00 03000 ADULTS & PEDIATRICS 31.00 41.00		11. 00			
31 .00		T			
41.00					
42. 00 A2200 SUBPROVIDER					
ANCILLARY SERVICE COST CENTERS 50.00					
50.00 05000 05000 0520					42.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 05300 05300 ARSTHESI OLOGY 1.557819 53.00 05400 RADI OLOGY-DI AGNOSTIC 0.275989 54.00 05400 RADI OLOGY-DI AGNOSTIC 0.275989 54.00 05400 RADI OLOGY-DI AGNOSTIC 0.000000 56.00 05501 ONCOLOGY 0.366164 56.01 05501 ONCOLOGY 0.366164 56.01 05501 ONCOLOGY 0.366164 57.00 05500 MCRUETIC RESONANCE IMAGING (MRI) 0.106722 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.106722 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 05900 CARDI AC CATHETERI ZATI ON 0.000000 05900 CARDI AC CATHETERI ZATI ON 0.000000 05900 05900 CARDI AC CATHETERI ZATI ON 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		0.400705			50.00
53.00 05300 ABSTHESI OLOCY 1.557819 53.00 05400 RADIOLOGY-DI AGNOSTI C 0.275989 54.00 05600 RADIOLOGY-DI AGNOSTI C 0.275989 56.00 05600 RADIOLOGY-DI AGNOSTI C 0.000000 56.01 05601 05601 0500					l l
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 275989 54. 00 05600 RADI OLOGY-DI AGNOSTI C 0. 000000 56. 01 05601 0NCOLOGY 0. 366164 56. 01 57. 00 05700 CT SCAN 0. 069626 57. 00 05900 CARDI AC CATHETERI ZATI ON 0. 069626 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0. 106722 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0. 106722 58. 00 05900 CARDI AC CATHETERI ZATI ON 0. 000000 0. 00000 LABORATORY 0. 179372 06. 01 06001 BLOOD LABORATORY 0. 000000 0. 179372 0. 000000 0. 000000 0. 00000 0. 00000 0. 00000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 000000					
56. 00 05600 RADI OI SOTOPE 0.000000 56. 01 05601		l l			
56. 01 05601 0KOOLOGY 0.366164 56. 01 57. 00 05700 CT SCAN 0.069626 57. 00 58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)					
57. 00 05700 CT SCAN 0.05900 CASDI AGNANCE IMAGING (MRI) 0.106722 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.106722 58. 00 05900 CARDIAC CATHETERIZATION 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000					l l
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0. 106722 59. 00 05900 CARDIAC CATHETERI ZATION 0. 000000 0. 000000 CARDIAC CATHETERI ZATION 0. 0000000 0. 00000 CARDIAC CATHETERI ZATION 0. 0000000 0. 000000 CARDIAC CATHETERI ZATION 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000					
59, 00 05900 CARDI AC CATHETERIZATION 0,000000 0,00000 0,0000 0,0000 0,0000 0,0000 0,0000 0,0000 0,00000 0,00000 0,00000 0,00000 0,00000 0,00000 0,00000 0,000000 0,000000 0,000000 0,000000 0,000000 0,000000 0,000000 0,000000 0,000000 0,000000 0,000000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,00000000					
60. 00 06000 LABORATORY 0. 179372 60. 00 60. 01 60. 00 60. 00 60. 01 60. 01 60. 00 60. 01 60. 00 60. 01 60. 00 60. 00 60. 01 60. 00 60. 01 60. 00		1			
60. 01 06001 BLOOD LABORATORY 0.000000 65. 00 65. 00 65. 00 65. 00 65. 00 65. 01 65. 01 65. 01 66. 01 66. 01 66. 01 66. 01 66. 01 66. 01 66. 01 66. 01 66. 01 66. 01 66. 00 6					
65. 00 06500 RESPIRATORY THERAPY 0.331100 65. 00 66. 01 06501 SLEEP LAB 0.219850 65. 01 66. 00 06600 PHYSI CAL THERAPY 0.397509 66. 00 06900 ELECTROCARDI OLOGY 0.221228 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.235949 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.253608 72. 00 07300 DRUGS CHARGED TO PATIENTS 0.344620 73. 00 00000 RDRAL HEALTH CLINIC 88. 00 08800 RURAL HEALTH CLINIC 89. 00 09000 CLINIC CLINIC 89. 00 09000 EDERALLY QUALIFIED HEALTH CENTER 99. 00 09000 DIRAL MEALTH CLINIC 4.542543 99. 00 91. 00 DIRAL MEALTH CLINIC 99. 00 09000 OBSERVATION BEDS (NON-DISTINCT PART) 0.453994 92. 00 09000 OBSERVATION BEDS (NON-DISTINCT PART) 0.453994 97. 00 09700 DIRABLE MEDI CAL EQUI P-SOLD 0.000000 100. 00 10000 18R SERVI CES-NOT APPRVD PRGM 101. 00 10100 HOME HEALTH AGENCY 9P. 00 100. 00 10000 1 RR SERVI CES-NOT APPRVD PRGM 101. 00 10100 HOME HEALTH AGENCY 9P. 00 100. 00 100. 01 10000 IRR SERVI CES-NOT APPRVD PRGM 101. 00 10100 HOME HEALTH AGENCY 9P. 00 100. 00 100. 01 10000 LR SERVI CES-NOT APPRVD PRGM 101. 00 10100 HOME HEALTH AGENCY 9P. 00 100. 00 100. 01 100. 0					
65. 01 06501 SLEEP LAB 0. 219850 0. 397509 0. 397509 0. 397509 0. 20128	1 I	1			
66. 00		1			
69. 00 06900 ELECTROCARDI OLOGY					l l
71. 00		1			l l
72. 00		1			
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.344620		1			
SERUL CENTRES SERVICE COST CENTERS					
88. 00 89. 00 89. 00 89. 00 89. 00 89. 00 90		0. 344620			/3.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC 4. 542543 90. 00 91. 00 09100 EMERGENCY 0. 161090 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 453994 92. 00 OFFICIAL PROPERTY OFFICE OFF					88 00
90. 00 09000 CLINIC 4. 542543 90. 00 91. 00 991. 00 991. 00 992. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 453994 92. 00 09700 OBSERVATION BEDS (NON-DISTINCT PART) 0. 453994 92. 00 09700 OBSERVATION BEDS (NON-DISTINCT PART) 0. 453994 92. 00 09700 OBSERVATION BEDS (NON-DISTINCT PART) 0. 453994 92. 00 09700 OP700					
91. 00 09100 EMERGENCY 0. 161090 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 453994 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0. 000000 18R SERVI CES-NOT APPRVD PRGM 100. 00 10000 I MBULANCE SERVI CES-NOT APPRVD PRGM 100. 00 10100 HOME HEALTH AGENCY 101. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE Subtotal (see instructions) Less Observation Beds 200. 00 201. 00 Less Observation Beds 201. 00		4 542543			
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0. 453994 92. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0. 000000 95. 00 97. 00 10000 1 & SERVI CES NOT APPRVD PRGM 100. 00 10100 HOME HEALTH AGENCY 101. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE Subtotal (see instructions) Less Observation Beds 201. 00 201. 00 201. 00 0. 453994 92. 00 95. 00 95. 00 97. 00		1			
OTHER REI MBURSABLE COST CENTERS O. 0000000 95. 00					
95. 00 09500 AMBULANCE SERVI CES 0. 000000 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0. 000000 97. 00 100. 00 10000 1 &R SERVI CES-NOT APPRVD PRGM 100. 00 10100 HOME HEALTH AGENCY 101. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00 201		0. 400774			72.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0. 000000 100. 0		0.000000			95.00
100. 00					l l
101. 00					
SPECIAL PURPOSE COST CENTERS 113.00 11300 1 NTEREST EXPENSE 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00					
113. 00 1130					
201. 00 Less Observation Beds 201. 00					113. 00
201. 00 Less Observation Beds 201. 00					
202.00 10tal (See Histractions)	202.00 Total (see instructions)				202. 00

Health Financial Systems	MAJOR HO	OSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der (CCN: 15-0097	Peri od: From 01/01/2016	Worksheet C Part I	
					Date/Time Pre 5/25/2017 11:	
		Ti t	le XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
INDATIENT DOUTINE SERVICE COST CENTERS						

					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	•	(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.	1				
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.0		13, 243, 753		13, 243, 753	0	13, 243, 753	30.00
31. 0	1 I	2, 984, 990		2, 984, 990		2, 984, 990	31. 00
41. 0	1 I	2,701,770		2,701,770	0	0	41. 00
42. (1			o o	0	0	42. 00
12. (ANCILLARY SERVICE COST CENTERS				٥	0	12.00
50. 0		8, 062, 312		8, 062, 312	0	8, 062, 312	50. 00
52. 0	1	0,002,012	l .	0,002,012	0	0	52. 00
53. 0		2, 224, 451		2, 224, 451	140, 578	2, 365, 029	53. 00
54. (1	6, 676, 255		6, 676, 255		6, 676, 255	54. 00
56. (1 1	0,070,233		0, 070, 233	0	0, 070, 233	56. 00
56. (1	4, 060, 594		4, 060, 594	4, 105	4, 064, 699	56. 01
	1						57. 00
57. 0 58. 0		1, 593, 437		1, 593, 437		1, 593, 437 1, 094, 596	
		1, 094, 596		1, 094, 596	0		
59. ((000 400		(000 400	0	0	59. 00
60.0		6, 933, 188		6, 933, 188	0	6, 933, 188	60.00
60. 0			_		0	0	60. 01
65. (1, 726, 619		., . = = , =		1, 726, 619	65. 00
65. (964, 192		964, 192		964, 192	65. 01
66. 0		2, 919, 283		2, 919, 283		2, 921, 021	
69. (1, 285, 699		1, 285, 699		1, 285, 699	69. 00
71. (2, 489, 805		2, 489, 805	0	2, 489, 805	
72. 0	00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 577, 623		2, 577, 623	0	2, 577, 623	72. 00
73. 0		9, 975, 381		9, 975, 381	0	9, 975, 381	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 0		0		0	0	0	88. 00
89. (00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89. 00
90. 0	00 09000 CLI NI C	571, 711		571, 711	50, 949	622, 660	90. 00
91. (00 09100 EMERGENCY	6, 752, 159		6, 752, 159	360, 523	7, 112, 682	91.00
92. 0	00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 421, 787		1, 421, 787		1, 421, 787	92.00
	OTHER REIMBURSABLE COST CENTERS						
95. (00 09500 AMBULANCE SERVICES	0		0	0	0	95. 00
97. 0	00 09700 DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97. 00
100.	00 10000 I &R SERVICES-NOT APPRVD PRGM	0		0		0	100. 00
101.	00 10100 HOME HEALTH AGENCY	1, 916, 518		1, 916, 518		1, 916, 518	101. 00
	SPECIAL PURPOSE COST CENTERS						
113.	00 11300 I NTEREST EXPENSE						113. 00
200.	00 Subtotal (see instructions)	79, 474, 353	0	79, 474, 353	557, 893	80, 032, 246	200. 00
201.	00 Less Observation Beds	1, 421, 787		1, 421, 787		1, 421, 787	201. 00
202.	00 Total (see instructions)	78, 052, 566	0	78, 052, 566	557, 893	78, 610, 459	202. 00
			•				•

Peri od: Worksheet C From 01/01/2016 To 12/31/2016 Date/Time Prepared: 5/25/2017 11: 27 am Provider CCN: 15-0097

				V/1 V/		5/25/201/ 11:	21 alli
				e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6		TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	15, 840, 443		15, 840, 44	3		30. 00
31.00	03100 INTENSIVE CARE UNIT	3, 650, 056		3, 650, 05	5		31.00
41.00	04100 SUBPROVI DER - I RF	0					41.00
42.00	04200 SUBPROVI DER	o					42.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATI NG ROOM	10, 113, 287	32, 379, 280	42, 492, 56	0. 189735	0.000000	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0. 000000	0. 000000	1
53. 00	05300 ANESTHESI OLOGY	293, 327	1, 224, 840	1, 518, 16 ⁻		0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 370, 394	21, 819, 899			0. 000000	1
56. 00	05600 RADI OI SOTOPE	2,0,0,0,1	21,017,077			0. 000000	1
56. 01	05601 ONCOLOGY	44, 569	11, 056, 184			0. 000000	
57. 00	05700 CT SCAN	3, 386, 668	19, 499, 088			0. 000000	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	765, 516	9, 491, 039			0. 000000	
59. 00		700, 010				0. 000000	
	05900 CARDI AC CATHETERI ZATI ON	7 (57 110	0 005 533		0.00000		
60.00	06000 LABORATORY	7, 657, 119	30, 995, 532			0.000000	
60. 01	06001 BLOOD LABORATORY	0	0		0.000000	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	4, 387, 690	827, 107			0. 000000	
65. 01	06501 SLEEP LAB	5, 308	4, 380, 373			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	1, 192, 586	6, 155, 730			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	731, 429	5, 080, 209			0. 000000	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 616, 800	7, 935, 492			0. 000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	5, 282, 334	4, 881, 454			0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	8, 397, 808	20, 548, 223	28, 946, 03	0. 344620	0. 000000	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0		0.000000	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0.000000	0.000000	89. 00
90.00	09000 CLI NI C	202	136, 871	137, 07	4. 170851	0.000000	90.00
91.00	09100 EMERGENCY	6, 433, 310	37, 720, 225	44, 153, 53	0. 152925	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	3, 131, 733	3, 131, 73	0. 453994	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS	'					1
95.00	09500 AMBULANCE SERVI CES	0	0		0.000000	0.000000	95. 00
97. 00		0	0		0. 000000	0. 000000	1
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0				100.00
	10100 HOME HEALTH AGENCY		2, 250, 052	2, 250, 05			101. 00
101.0	SPECIAL PURPOSE COST CENTERS	۷۱	2,200,002	2, 200, 00.	=		1.01.00
113 ∩	11300 INTEREST EXPENSE						113. 00
200.00		73, 168, 846	219, 513, 331	292, 682, 17	7		200. 00
200.00		73, 100, 040	∠17, J13, J31	272,002,17	<u> </u>		201. 00
201.00		73, 168, 846	219, 513, 331	202 402 17	7		201.00
202.00	p local (See Histiactions)	/3, 100, 040	217, 313, 331	292, 682, 17	'I I	l	1202.00

			To 12/31/2016	Date/Time Prepared: 5/25/2017 11:27 am
-		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Rati o			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS	T			
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31. 00 03100 INTENSIVE CARE UNIT				31.00
41. 00 04100 SUBPROVI DER - RF 42. 00 04200 SUBPROVI DER				41. 00 42. 00
ANCI LLARY SERVI CE COST CENTERS				42.00
50. 00 05000 OPERATING ROOM	0. 000000			50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 000000			54.00
56. 00 05600 RADI 01 SOTOPE	0. 000000			56.00
56. 01 05601 0NCOLOGY	0. 000000			56. 01
57. 00 05700 CT SCAN	0. 000000			57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00 06000 LABORATORY	0. 000000			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
65. 01 06501 SLEEP LAB	0. 000000			65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89. 00
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			97. 00
100.00 10000 I&R SERVICES-NOT APPRVD PRGM				100. 00
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202.00

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2016 To 12/31/2016		
			XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Days	Per Diem (col. 3 / col. 4)	
	26)		2)			
LANDATA ENT. DOUTLANE, OFFICE OF COOT, OFFITEDO	1.00	2.00	3.00	4. 00	5. 00	
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 41.00 SUBPROVIDER - IRF 42.00 SUBPROVIDER 200.00 Total (lines 30-199) Cost Center Description	632,878 178,484 0 0 811,362 Inpatient Program days	0	632, 87 178, 48 811, 36	4 1, 098 0 0 0 0	162. 55 0. 00 0. 00	31. 00 41. 00
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 41.00 SUBPROVIDER - IRF 42.00 SUBPROVIDER 200.00 Total (lines 30-199)	4, 263 508 0 0 4, 771	82, 575 0 0				30. 00 31. 00 41. 00 42. 00 200. 00

Health Financial Systems	MAJOR HC	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	TAL COSTS	Provi der C		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 11:	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	0.00		4 00		
ANOLLI ADV. CEDVI OF COCT. CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	050.040	10 100 517		0 000 (00	17.000	
50. 00 05000 OPERATING ROOM	258, 063				17, 209	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	1	0.00000		0	52.00
53. 00 05300 ANESTHESI OLOGY	19, 739		1		995	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	227, 215				12, 111	54. 00 56. 00
56. 00 05600 RADI OI SOTOPE	0		0.0000		0	
56. 01 05601 0NCOLOGY 57. 00 05700 CT SCAN	369, 925		1	· ·	231	56. 01 57. 00
	19, 750				1, 579 275	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	6, 568		0. 00064 0. 00000		2/5	58. 00 59. 00
60. 00 06000 LABORATORY	79, 266	1			7, 913	
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	79, 200		0.00205		7, 913	60.00
65. 00 06500 RESPI RATORY THERAPY	27, 967	1			10, 355	65. 00
65. 00 06500 RESPIRATORY THERAPY	4, 649				10, 355	65. 00
66. 00 06600 PHYSI CAL THERAPY	27, 922		l .	· ·	2, 846	66. 00
69. 00 06900 ELECTROCARDI OLOGY	67, 574				2, 646 8, 111	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	44, 716		1		6, 479	71.00
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	41, 198		1		7, 262	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	64, 422				8, 753	73.00
OUTPATIENT SERVICE COST CENTERS	04, 422	20, 740, 031	0.00222	0 3, 732, 177	0, 733	73.00
88. 00 08800 RURAL HEALTH CLINIC			0.00000	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0. 00000		0	89. 00
90. 00 09000 CLINIC	108, 456	137, 073			0	90.00
91. 00 09100 EMERGENCY	158, 278		1		11, 747	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	67, 943				0	92. 00
OTHER REIMBURSABLE COST CENTERS	37,743	5, 101, 700	0.02107	<u> </u>		72.00
95. 00 09500 AMBULANCE SERVICES						95. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0. 00000	o o	0	97. 00
200.00 Total (lines 50-199)	1, 593, 651	270, 941, 626		24, 235, 563	_	
	•	•	•			

Nursing School All I other Cost Cost	Health Financial Systems	MAJOR HO	SPI TAL		In Li∈	eu of Form CMS-:	2552-10		
Nursing School Allied Health Cost Medical Education Cost Medical Adjustment Amount (see instructions) 1.00 2.00 3.00 4.00 5.00	APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS			From 01/01/2016 To 12/31/2016	Part III Date/Time Pre 5/25/2017 11:			
NPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00					Hospi tal	PPS			
NPATIENT ROUTINE SERVICE COST CENTERS	Cost Center Description	Nursing School	Allied Health	All Other		Total Costs			
INPATI ENT ROUTI NE SERVI CE COST CENTERS			Cost	Medi cal	Adjustment	(sum of cols.			
NPATI ENT ROUTI NE SERVI CE COST CENTERS 1.00 2.00 3.00 4.00 5.00				Education Cos	st Amount (see	1 through 3,			
INPATIENT ROUTINE SERVICE COST CENTERS 0					instructions)	minus col. 4)			
30.00		1.00	2.00	3. 00	4. 00	5. 00			
31.00	INPATIENT ROUTINE SERVICE COST CENTERS								
A1. 00	30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00		
A2. 00	31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00		
Total (lines 30-199)	41. 00 04100 SUBPROVI DER - I RF	0	0		0 0	0	41.00		
Total Patient Per Diem (col. Inpatient Program Days Prog	42, 00 04200 SUBPROVI DER	0	l o		0 0	0	42.00		
Total Patient Per Diem (col. Inpatient Program Days Prog	200.00 Total (lines 30-199)	0	0		0	0	200.00		
Days 5 ÷ col . 6) Program Days Program Pass-Through Cost (col . 7 x col . 8)		Total Patient	Per Diem (col.	Inpatient	Inpati ent				
Pass-Through Cost (col. 7 x col. 8) 6.00 7.00 8.00 9.00									
Cost (col. 7 x col. 8) 6.00 7.00 8.00 9.00			,						
INPATIENT ROUTINE SERVICE COST CENTERS									
INPATIENT ROUTINE SERVICE COST CENTERS 10,442 0.00 4,263 0 30.00 31.00 03100 INTENSIVE CARE UNIT 1,098 0.00 508 0 31.00 41.00 04100 SUBPROVIDER - IRF 0 0.00 0 0 0 42.00 04200 SUBPROVIDER 0 0.00 0 0 0 0 0 0 0									
30. 00		6, 00	7. 00	8, 00					
31. 00 03100 INTENSIVE CARE UNIT									
31. 00 03100 INTENSIVE CARE UNIT	30. 00 03000 ADULTS & PEDIATRICS	10, 442	0.00	4. 26	53 0		30.00		
41. 00 04100 SUBPROVI DER - I RF 0 0. 00 0 41. 00 0 42. 00 04200 SUBPROVI DER 0 0 0 0 0 0 0 0 0	31.00 03100 INTENSIVE CARE UNIT	1					31.00		
42. 00 04200 SUBPROVI DER 0 0. 00 0 42. 00		0			0				
					0				
200.00		11 540			71				
	200.00 10101 (11103 00 177)	11,540	I	1 7,7,		I	1200.00		

Health Financial Systems	MAJOR HOSPI	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0097		Worksheet D
TUDOUGU COCTO			From 01/01/2016	Dart IV

THROUGH COSTS To 12/31/2016 Date/Time Prepared: 5/25/2017 11:27 am Title XVIII Hospi tal PPS Cost Center Description Non Physician Nursing School Allied Health All Other Total Cost Anestheti st Medi cal (sum of col 1 through col . Cost Education Cost 1.00 2.00 3.00 4. 00 5.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 0 53.00 05300 ANESTHESI OLOGY 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 0 56.00 05600 RADI OI SOTOPE 0 0 0 56.00 05601 ONCOLOGY 0 56.01 0 56.01 57.00 05700 CT SCAN 0 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 05900 CARDIAC CATHETERIZATION 0 59 00 0 0 59.00 0 60.00 06000 LABORATORY 0 60.00 60. 01 06001 BLOOD LABORATORY 60.01 06500 RESPIRATORY THERAPY 0 65.00 65.00 06501 SLEEP LAB 0 65.01 65.01 0 66.00 06600 PHYSI CAL THERAPY 0 66.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 71 00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 88. 00 n 0 0 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 0 0 89.00 0 0 09000 CLI NI C 0 90.00 90.00 0 0 91.00 09100 EMERGENCY 0 Ω 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 0 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 97.00 οl

0 200. 00

200.00

Total (lines 50-199)

Health Financial Systems	MAJOR	HOSPI TA	۸L		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANTHROUGH COSTS	CILLARY SERVICE OTHER F	PASS P	rovi der CC		Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Pre 5/25/2017 11:	
			Title	XVIII	Hospi tal	PPS	
Cost Conton Docomintion	Total	Toto	Charges	Dotio of Coo	t Outpotiont	Innotiont	

					0 12/31/2016	5/25/2017 11:	pared: 27 am
			Ti tl e	e XVIII	Hospi tal	PPS	
Cost (Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	Inpati ent	
			(from Wkst. C,	to Charges	Ratio of Cost	Program	
		Cost (sum of		(col. 5 ÷ col.		Charges	
		col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6. 00	7. 00	8. 00	9. 00	10. 00	
	ERVI CE COST CENTERS						
50. 00 05000 OPERA		0	42, 492, 567			2, 833, 630	
	ERY ROOM & LABOR ROOM	0		0.000000		0	52. 00
53. 00 05300 ANESTH		0	1, 518, 167	•		76, 543	53. 00
	LOGY-DI AGNOSTI C	0	24, 190, 293			1, 289, 390	
56. 00 05600 RADI 01		0	(0.000000		0	56. 00
56. 01 05601 0NCOLO		0	11, 100, 753			6, 944	56. 01
57. 00 05700 CT SCA		0	22, 885, 756	l		1, 829, 400	57. 00
	TIC RESONANCE IMAGING (MRI)	0	10, 256, 555			429, 546	58. 00
	AC CATHETERIZATION	0	C	0. 000000		0	59. 00
60. 00 06000 LABORA		0	38, 652, 651			3, 858, 175	60. 00
60. 01 06001 BL00D		0	C	0. 000000		0	60. 01
	RATORY THERAPY	0	5, 214, 797			1, 930, 807	65. 00
65. 01 06501 SLEEP		0	4, 385, 681			5, 308	65. 01
66. 00 06600 PHYSI (0	7, 348, 316			748, 929	66. 00
	ROCARDI OLOGY	0	5, 811, 638			697, 595	69. 00
	AL SUPPLIES CHARGED TO PATIENTS	0	10, 552, 292	•		1, 528, 747	71. 00
72. 00 07200 I MPL.	DEV. CHARGED TO PATIENT	0	10, 163, 788	0. 000000	0.000000	1, 791, 673	72. 00
	CHARGED TO PATIENTS	0	28, 946, 031	0.000000	0.000000	3, 932, 197	73. 00
	SERVICE COST CENTERS						
	HEALTH CLINIC	0	C	0. 000000		0	88. 00
	ALLY QUALIFIED HEALTH CENTER	0	C	0. 000000		0	89. 00
90. 00 09000 CLI NI (0	137, 073	1		0	90. 00
91. 00 09100 EMERGE		0	44, 153, 535			3, 276, 679	91. 00
	VATION BEDS (NON-DISTINCT PART)	0	3, 131, 733	0. 000000	0.000000	0	92.00
	URSABLE COST CENTERS						
95. 00 09500 AMBULA							95. 00
	LE MEDICAL EQUIP-SOLD	0	C	0. 000000	0. 000000	0	97. 00
200. 00 Total	(lines 50-199)	0	270, 941, 626			24, 235, 563	200. 00

Health Financial Systems	MAJOR HOSPI	In Lieu	u of Form CMS-2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0097	From 01/01/2016	Worksheet D Part IV Date/Time Prepared: 5/25/2017 11: 27 am

				10 12/31/2010	5/25/2017 11	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. (9		
	x col. 10)		x col. 12)			
	11.00	12.00	13. 00			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	8, 602, 667		0		50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52. 00
53. 00 05300 ANESTHESI OLOGY	0	213, 809		0		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	5, 639, 921		0		54. 00
56. 00 05600 RADI 0I SOTOPE	0	0		0		56. 00
56. 01 05601 ONCOLOGY	0	4, 213, 603		0		56. 01
57.00 05700 CT SCAN	0	5, 269, 010		0		57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	2, 396, 678		0		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0		59. 00
60. 00 06000 LABORATORY	0	3, 890, 402		0		60.00
60. 01 06001 BLOOD LABORATORY	0	0		0		60. 01
65. 00 06500 RESPIRATORY THERAPY	0	473, 519		0		65. 00
65. 01 06501 SLEEP LAB	0	1, 070, 916		0		65. 01
66. 00 06600 PHYSI CAL THERAPY	0	79, 041		0		66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	2, 483, 852		0		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 705, 806		0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	1, 655, 702		0		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	5, 733, 530		0		73. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>		•			
88.00 08800 RURAL HEALTH CLINIC	0	0		0		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	O	0		0		89. 00
90. 00 09000 CLI NI C	0	0		0		90.00
91. 00 09100 EMERGENCY	0	8, 926, 817		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	976, 579		o		92.00
OTHER REIMBURSABLE COST CENTERS			<u>'</u>			
95. 00 09500 AMBULANCE SERVI CES						95. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0		0		97. 00
200.00 Total (lines 50-199)	O	53, 331, 852		0		200. 00
			•	•		

Health Fi	nancial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTI ON	IMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Peri od:	Worksheet D	
					From 01/01/2016 To 12/31/2016	Part V	nanad.
					To 12/31/2016	Date/Time Pre 5/25/2017 11:	pareu: 27 am
			Title	: XVIII	Hospi tal	PPS	27 diii
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	· ·	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins.			
				(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	CILLARY SERVICE COST CENTERS	0.100705		T		4 (00 007	
	000 OPERATING ROOM	0. 189735	8, 602, 667		0	1, 632, 227	1
	200 DELIVERY ROOM & LABOR ROOM	0.000000	040.000		0	0	
	300 ANESTHESI OLOGY	1. 465222	213, 809		0	313, 278	
	400 RADI OLOGY-DI AGNOSTI C	0. 275989	5, 639, 921		0	1, 556, 556	
	600 RADI OI SOTOPE	0. 000000			0	0	
	601 ONCOLOGY	0. 365794			0	1, 541, 311	
	700 CT SCAN	0. 069626	5, 269, 010		0	366, 860	
	800 MAGNETIC RESONANCE IMAGING (MRI)	0. 106722	2, 396, 678	1	0	255, 778	
	900 CARDI AC CATHETERI ZATI ON	0.000000	0 000 400	l .	0	0	
	000 LABORATORY	0. 179372		•		697, 829	
	001 BLOOD LABORATORY	0.000000		l .	0	0	
	500 RESPIRATORY THERAPY	0. 331100			0	156, 782	
	501 SLEEP LAB	0. 219850			0	235, 441	
	600 PHYSI CAL THERAPY	0. 397272	79, 041	•	0	31, 401	
	900 ELECTROCARDI OLOGY	0. 221228			0	549, 498	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 235949			0	402, 483	
	200 IMPL. DEV. CHARGED TO PATIENT 300 DRUGS CHARGED TO PATIENTS	0. 253608 0. 344620			0 11 400	419, 899 1, 975, 889	
	TPATIENT SERVICE COST CENTERS	0. 344620	5, 733, 530		0 11, 408	1, 9/5, 889	73.00
	800 RURAL HEALTH CLINIC	0. 000000		I		0	88. 00
	900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
	000 CLINIC	4. 170851	0		0	0	1
	100 EMERGENCY	0. 152925	8, 926, 817		0 0	1, 365, 133	
	200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 453994	976, 579		0 0		
	HER REIMBURSABLE COST CENTERS	0.453774	770, 377		0 0	443, 301	72.00
	500 AMBULANCE SERVICES	0. 000000			ol		95. 00
	700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			0	0	
200. 00	Subtotal (see instructions)	3. 000000	53, 331, 852	36	3 11, 408	_	
201. 00	Less PBP Clinic Lab. Services-Program		00,001,002		0 11,400	11, 710, 720	201. 00
	Only Charges				-		
202. 00	Net Charges (line 200 +/- line 201)		53, 331, 852	36	3 11, 408	11, 943, 726	202. 00

				10 12/31/2016	5/25/2017 11: 2	
		Title	XVIII	Hospi tal	PPS	
	Cos	ts		<u> </u>		
Cost Center Description	Cost	Cost				
·	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
56. 00 05600 RADI 0I SOTOPE	0	0				56.00
56. 01 05601 0NC0L0GY	o	0				56. 01
57. 00 05700 CT SCAN	o	0				57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	o	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60. 00 06000 LABORATORY	65	0				60. 00
60. 01 06001 BLOOD LABORATORY	0	0				60. 01
65. 00 06500 RESPI RATORY THERAPY	0	0				65. 00
65. 01 06501 SLEEP LAB	0	0				65. 01
66. 00 06600 PHYSI CAL THERAPY	0	0				66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	3, 931				73. 00
OUTPATIENT SERVICE COST CENTERS		0, 701				70.00
88. 00 08800 RURAL HEALTH CLINIC	0	0				88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
90. 00 09000 CLI NI C	0	0				90. 00
91. 00 09100 EMERGENCY	0	0				91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92. 00
OTHER REIMBURSABLE COST CENTERS		<u> </u>				72.00
95. 00 09500 AMBULANCE SERVICES	0					95. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0				97. 00
200.00 Subtotal (see instructions)	65	3, 931				200. 00
201.00 Less PBP Clinic Lab. Services-Program	03	3, 731				200.00
Only Charges						201.00
202.00 Net Charges (line 200 +/- line 201)	65	3, 931				202. 00
202.00 Net ondiges (Time 200 17 Time 201)	1 03	3, 731	I		ļ	202.00

Health Financial Systems	MAJOR HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0097	Peri od: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/25/2017 11:27 am
	Title XVIII	Hospi tal	PPS

				5/25/2017 11:	27 am
		Title XVIII	Hospi tal	PPS	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				1
	I NPATI ENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed days		10, 442		
2.00	Inpatient days (including private room days, excluding swing-			10, 442	1
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	vate room days,	0	3. 00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be			9, 321	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	5. 00
	reporting period			_ '	
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December :	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)		04 6 11		
7. 00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 or the cost	0	7. 00
0.00	reporting period		1 6 11		
8. 00	Total swing-bed NF type inpatient days (including private roor	n days) after becember 3	or the cost	0	8. 00
0 00	reporting period (if calendar year, enter 0 on this line)	- +l D (l		4.2(2	0.00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	4, 263	9. 00
10.00	newborn days)				10 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruc-		Joili days)	0	10.00
11 00	Swing-bed SNF type inpatient days applicable to title XVIII or		nom dave) after	0	11.00
11. 00	December 31 of the cost reporting period (if calendar year, en		Juli days) arter		11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)		n room days)	0	12.00
12.00	through December 31 of the cost reporting period	Comy (including private	e room days)		12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	/ only (including private	n room days)	0	13.00
13.00	after December 31 of the cost reporting period (if calendar ve				13.00
14. 00	Medically necessary private room days applicable to the Progra			0	14.00
15. 00	Total nursery days (title V or XIX only)	ill (excluding swing-bed to	uays)		
16. 00	Nursery days (title V or XIX only)				
10.00	SWING BED ADJUSTMENT				10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	os through Docombor 21 o	f the cost	0.00	17. 00
17.00	reporting period	es through becember 31 0	the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	s after December 31 of	the cost	0.00	18. 00
10.00	reporting period	es arter becember 31 or	the cost	0.00	16.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19.00
17.00	reporting period	s till odgir beceiliber 31 of	the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of the	ne cost	0.00	20.00
20.00	reporting period	dittel becomber of or	10 0051	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions	5)		13, 243, 753	21.00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line		1
22.00	5 x line 17)	5. 6. 6. the 666t report	ing pointed (initial		22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	O	23. 00
	x line 18)		9		
24.00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24.00
	7 x line 19)		5		
25.00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)				
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		13, 243, 753	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	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	1
34.00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x lin	ne 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 a	and private room cost di	fferential (line	13, 243, 753	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 268. 32	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		5, 406, 848	1
40.00	Medically necessary private room cost applicable to the Progra	am (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ line 40)		5, 406, 848	41.00

	Financial Systems	MAJOR HOS				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der Co	CN: 15-0097	Peri od: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Pre 5/25/2017 11:	pared:
			Title	XVIII	Hospi tal	PPS	27 diii
	Cost Center Description	Total Inpatient Cost	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
42.00	NUDCEDY (4: 41 - V 0 VIV1.)	1.00	2. 00	3. 00	4. 00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42. 00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	2, 984, 990	1, 098	2, 718.	57 508	1, 381, 034	43. 00 44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description					1 00	47. 00
48. 00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3.	Line 200)			1. 00 5, 671, 078	48. 00
	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ns)		12, 458, 960	
50.00	Pass through costs applicable to Program inp		•			340, 955	
51. 00 52. 00	Pass through costs applicable to Program inp and IV) Total Program excludable cost (sum of lines	,	services (fr	om WKST. D,	sum от Parts II	95, 872 436, 827	51.00
53. 00	Total Program excludable cost (sum of fines) Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	ding capital rel	ated, non-phy	sician anest	hetist, and	12, 022, 133	
	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0. 00 0	55. 00 56. 00
57. 00	Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	1
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re market basket	porting period e	endi ng 1996, u	pdated and c	ompounded by the	0 0. 00	58. 00 59. 00
60. 00 61. 00	.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0. 00 0	60. 00 61. 00
	amount (line 56), otherwise enter zero (see		(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,			
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)				62. 00
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decem	ber 31 of the	cost report	ing period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)			•		0	
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)				•		66.00
67. 00 68. 00	(line 12 x line 19)	•				0	67. 00
	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient				ortring period		69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY,	AND ICF/IID	ONLY	,		
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c)		70.00
72. 00 73. 00	Program routine service cost (line 9 x line	•	(line 14 v li	no 3E)			72. 00 73. 00
74.00	Medically necessary private room cost applic Total Program general inpatient routine serv			iie 33)			74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service		orksheet B,	Part II, column		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	76)					76. 00 77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ovi den inecond	s)			78. 00 79. 00
					nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi						81. 00 82. 00
82.00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82.00
84.00	Program inpatient ancillary services (see in	structions)					84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•					85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	9 00/				
	Total observation bed days (see instructions)				1, 121	87. 00
87. 00 88. 00	Adjusted general inpatient routine cost per	diem (line 27 ·	line 2)			1, 268. 32	88 00

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH O	COST					
90.00 Capital -related cost	632, 878	13, 243, 753	0. 04778	7 1, 421, 787	67, 943	90.00
91.00 Nursing School cost	0	13, 243, 753	0.00000	0 1, 421, 787	0	91.00
92.00 Allied health cost	0	13, 243, 753	0.00000	0 1, 421, 787	0	92.00
93.00 All other Medical Education	o	13, 243, 753	0. 00000	0 1, 421, 787	0	93. 00

Health Financial Systems	MAJOR HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		From 01/01/2016	Worksheet D-1 Date/Time Prepared: 5/25/2017 11: 27 am	
	Title XIX	Hospi tal	Cost	

		Title XIX	Hospi tal	5/25/2017 11:: Cost	27 am_	
	Cost Center Description		·	1. 00		
	PART I - ALL PROVIDER COMPONENTS			1.00		
1 00	I NPATI ENT DAYS			10 442	1 00	
1. 00 2. 00	Inpatient days (including private room days and swing-bed days			10, 442 10, 442	1. 00 2. 00	
3. 00	00 Private room days (excluding swing-bed and observation bed days). If you have only private room days,					
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		9, 321	4. 00	
5.00	Total swing-bed SNF type inpatient days (including private rooreporting period		31 of the cost	0	5. 00	
6.00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after December 3	31 of the cost	0	6. 00	
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00	
8.00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8. 00	
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swi ng-bed and	352	9. 00	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10. 00	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nly (including private ro	oom days) after	0	11. 00	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00	
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00	
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00	
10.00	SWING BED ADJUSTMENT			0	10.00	
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0. 00	17. 00	
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0. 00	18. 00	
19. 00	Medicald rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0. 00	19. 00	
20. 00	Medicald rate for swing-bed NF services applicable to services reporting period	after December 31 of t	ne cost	0. 00	20. 00	
21. 00	Total general inpatient routine service cost (see instructions			13, 243, 753		
22. 00	Swing-bed cost applicable to SNF type services through Decembe 5×1 ine 17)	er 31 of the cost reporti	ng period (line	0	22. 00	
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00	
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reporti	ng period (line	0	24. 00	
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00	
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		0 13, 243, 753	26. 00 27. 00	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0		
29. 00 30. 00	Private room charges (excluding swing-bed charges)			0	29. 00 30. 00	
31.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	30.00	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	1111C 20)		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 mir	nus line 33)(see instruc	tions)	0. 00	34. 00	
35. 00	Average per diem private room cost differential (line 34 x lir		,	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 a	and private room cost di	fferential (line	13, 243, 753	37. 00	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY					
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS				
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 268. 32	38. 00	
39. 00	Program general inpatient routine service cost (line 9 x line	•		446, 449	39. 00	
40. 00	Medically necessary private room cost applicable to the Progra	•		0	40. 00	
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		446, 449	41. 00	

Heal th	Financial Systems	MAJOR HOSE	PI TAL		In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provider CO	CN: 15-0097	Peri od: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Pre	pared:
	Cost Center Description	Total Inpatient Costli	Total	e XIX Average Per Diem (col. 1		5/25/2017 11:	27 am
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)						42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	2, 984, 990	1, 098	2, 718.	57 0	0	43. 00
44. 00	CORONARY CARE UNIT		,	,			44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
						1.00	
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ns)		368, 284 814, 733	1
50.00	Pass through costs applicable to Program inp	atient routine s	ervices (from	Wkst. D, sur	m of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inpand IV)	,	services (fr	om Wkst. D, s	sum of Parts II	0	51.00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu- medical education costs (line 49 minus line	ding capital rela	ated, non-phy	sician anestl	hetist, and	0	
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	1
57. 00	Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re market basket	porting period e	ndi ng 1996, u	pdated and co	ompounded by the	0.00	
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line which operating costs (line 53) are less than	s 55, 59 or 60 e n expected costs	nter the Less	er of 50% of	the amount by	0.00	1
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Decemb	ber 31 of the	cost reporti	ing period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions) (title XVIII only)	ts after Decembe	r 31 of the c	ost reportino	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)		•		•	0	
67. 00	(line 12 x line 19)	•				0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)				orting period	0	
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70.00	Skilled nursing facility/other nursing facil	ity/ICF/IID rout	ine service c	ost (line 37))		70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne 70 ÷ 11ne	2)			71. 00 72. 00
73. 00 74. 00	Medically necessary private room cost application. Total Program general inpatient routine serv			ne 35)			73. 00 74. 00
75. 00	Capital regian general ripatrent routine services (Capital related cost allocated to inpatient 26, line 45)			orksheet B, I	Part II, column		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	s line 77)		`			78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 79)		79. 00 80. 00
81. 00 82. 00	Inpatient routine service cost per diem limi	tati on			•		81. 00 82. 00
83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (· · · · · · · · · · · · · · · · · · ·)				83. 00
84. 00 85. 00	Program inpatient ancillary services (see in- Utilization review - physician compensation		(2				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 thre	•				86.00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					1, 121	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 268. 32	88. 00
89.00	Observation bed cost (line 87 x line 88) (se	e instructions)				1, 421, 787	89.00

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(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	632, 878	13, 243, 753	0. 04778	7 1, 421, 787	67, 943	90.00
91.00 Nursing School cost	0	13, 243, 753	0.00000	0 1, 421, 787	0	91.00
92.00 Allied health cost	0	13, 243, 753	0.00000	0 1, 421, 787	0	92.00
93.00 All other Medical Education	0	13, 243, 753	0. 00000	0 1, 421, 787	0	93. 00

	Financial Systems	MAJOR HOSPITAL			eu of Form CMS-2	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	
				From 01/01/2016 To 12/31/2016		nared:
				10 12/31/2010	5/25/2017 11:	
		Ti tl e	2 XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				1	
30. 00	03000 ADULTS & PEDIATRICS			5, 406, 212		30. 00
31.00	03100 I NTENSI VE CARE UNI T			1, 341, 120		31.00
41. 00	04100 SUBPROVI DER - I RF			0		41.00
42. 00	04200 SUBPROVI DER			0		42.00
F0 00	ANCILLARY SERVICE COST CENTERS		0.40076	0.000.400	F07 (00	F0 00
	05000 OPERATING ROOM		0. 18973		· ·	
52. 00 53. 00	O5200 DELI VERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY		0. 00000 1. 55781			52. 00 53. 00
54. 00	05400 RADI OLOGY - DI AGNOSTI C		0. 27598			54.00
56. 00	05600 RADI OI SOTOPE		0. 00000			56.00
56. 01	05601 0NCOLOGY		0. 36616			
57. 00	05700 CT SCAN		0. 06962			
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 10672			1
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 00000		13, 042	59.00
60.00	06000 LABORATORY		0. 17937		_	60.00
	06001 BLOOD LABORATORY		0.00000			60. 01
65. 00	06500 RESPI RATORY THERAPY		0. 33110		639, 290	
65. 01	06501 SLEEP LAB		0. 21985			65. 01
66. 00	06600 PHYSI CAL THERAPY		0. 39750			66. 00
69.00	06900 ELECTROCARDI OLOGY		0. 22122	8 697, 595	154, 328	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 23594			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		0. 25360			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 34462			73. 00
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC		0.00000	00	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000	00	0	89. 00
	09000 CLI NI C		4. 54254	13 0	0	90.00
01 00	00100 EMEDCENCY		0 14100	2 274 470	E27 040	01 00

0 97.00

5, 671, 078 200. 00

527, 840

91.00

92.00 95.00

201. 00 202. 00

0. 161090

0.453994

0.000000

3, 276, 679

24, 235, 563

24, 235, 563

91. 00 09100 EMERGENCY

200.00

201.00

202.00

92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES

Total (sum of lines 50-94 and 96-98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net Charges (line 200 minus line 201)

97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

Health Financial Systems	MAJOR HOSPITAL			u of Form CMS-2	<u> 2552-10</u>
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			From 01/01/2016 To 12/31/2016	Date/Time Pre	pared.
			12, 01, 2010	5/25/2017 11:	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
				2)	
LUBATI FUT DOUTLING OFFICE OF COST OFFITEDO		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			F(0,0(0)		00.00
30. 00 03000 ADULTS & PEDI ATRI CS			568, 869		30.00
31. 00 03100 I NTENSI VE CARE UNI T			108, 438		31.00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
42. 00 O4200 SUBPROVI DER ANCI LLARY SERVI CE COST CENTERS			l O		42. 00
50. 00 05000 OPERATING ROOM		0. 18973	5 330, 271	62, 664	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 00000		02, 004	52. 00
53. 00 05300 ANESTHESI OLOGY		1. 46522		46, 802	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 27598		18, 621	
56. 00 05600 RADI OI SOTOPE		0.00000		0	56.00
56. 01 05601 0NCOLOGY		0. 36579		92	56. 01
57. 00 05700 CT SCAN		0. 06962		6, 129	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 10672	2 18, 092	1, 931	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000	0 0	0	59. 00
60. 00 06000 LABORATORY		0. 17937	2 249, 133	44, 687	60.00
60. 01 06001 BL00D LABORATORY		0.00000	0 0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY		0. 33110	0 99, 752	33, 028	65.00
65. 01 06501 SLEEP LAB		0. 21985	0 0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY		0. 39727	2 18, 687	7, 424	
69. 00 06900 ELECTROCARDI OLOGY		0. 22122	8 13, 423	2, 970	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 23594	9 196, 735	46, 419	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 25360	8 0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 34462	0 282, 970	97, 517	73. 00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0.00000		0	
		0 00000		^	00 00

0.000000

4. 170851

0.152925

0.453994

0.000000

0 89.00

0

0 91.00

0 92.00

0 97.00

368, 284 200. 00

90. 00

95.00

201. 00 202. 00

0 0 0

1, 396, 755

1, 396, 755

89.00

90.00

91.00

92.00

95.00

200.00

201.00

202.00

09000 CLI NI C

09100 EMERGENCY

97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

08900 FEDERALLY QUALIFIED HEALTH CENTER

09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
09500 AMBURSABLE VICES

Total (sum of lines 50-94 and 96-98)

Net Charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

PART A - IMPATIENT MOSPITAL SERVICES UNDER IPPS 1.00			Title XVIII	Hospi tol	5/25/2017 11:	27 am
Next A - INVATIBIT MOSPITAL SERVICES UNDER IPPS			II LIE AVIII	Hospi tal	PPS	
1.00 DRK Amounts other than outlier Payments for discharges occurring prior to October 1 (see 5,729,43 1.01 1.01 DRK (mounts other than outlier payments for discharges occurring on or after October 1 (see 1,910,200 1.02 1.02 1.02 1.03 1.					1. 00	
1.00 DRC amounts other than outlier payments for discharges occurring on or after October 1 (see 1,790,200 1.02 1.02 1.02 1.02 1.03	1 00				0	1 00
1.02 10K3 anounts other than outlier payments for discharges occurring on or after October 1 (see 1,910,200 1.02		DRG amounts other than outlier payments for discharges occurring	g prior to October 1 (s	see	-	
1.03 ORC for Foderal specific operating payment for Model 4 BPCI for discharges occurring prior to October 0 1.03	1. 02	DRG amounts other than outlier payments for discharges occurring	g on or after October	1 (see	1, 910, 200	1. 02
1.04 Oktober 1 (see instructions)	1.03	DRG for federal specific operating payment for Model 4 BPCI for	discharges occurring p	orior to October	0	1. 03
2.00 Outlier payments for discharges (see instructions)	1. 04	DRG for federal specific operating payment for Model 4 BPCI for	di scharges occurri ng	on or after	0	1. 04
2.02 2.02 2.01 1 2.02 2.02 2.02 2.02 2.02 2.03 2.02 2.03 2.0		Outlier payments for discharges. (see instructions)				
Red days available divided by number of days in the cost reporting period (see instructions) 42.94 4.00			ns)			
Indirect Medical Education Adjustment Count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996, (see Instructions)	3.00	Managed Care Simulated Payments			0	3. 00
or before 12/31/1996, (see instructions) 1. OFFICE count for all lopathic and osteopathic programs which meet the criteria for an add-on to the cap 1. OFFICE count for all lopathic and osteopathic programs which meet the criteria for an add-on to the cap 1. OFFICE count for all lopathic and osteopathic programs which meet the criteria for an add-on to the cap 1. OFFICE count for all lopathic and osteopathic programs in accordance with 42 CFR 413.79(e) 1. OFFICE count for all lopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(c), 413.79(c)(2)(iv), 64 FR 26340 (Mby 12, 1998), and 67 FR 50069 (August 1, 2002). 1. OFFICE count for all lopathic and osteopathic programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (Mby 12, 1998), and 67 FR 50069 (August 1, 2002). 1. OFFICE count for related so July 1, 2011, see instructions. 1. OFFICE count for related so July 1, 2011, see instructions. 1. OFFICE count for related so July 1, 2011, see instructions. 2. OFFICE count for related so July 1, 2011, see instructions. 2. OFFICE count for related so July 3, 2011, see instructions. 3. OFFICE count for related so July 3, 2011, see instructions. 3. OFFICE count for related so July 3, 2011, see instructions. 4. OFFICE count for related so July 3, 2011, see instructions. 4. OFFICE count for related so July 3, 2011, see instructions. 5. OFFICE count for related so July 3, 2011, see instructions. 5. OFFICE count for related so July 3, 2011, see instructions. 6. OFFICE count for related so July 3, 2011, see instructions. 7. OFFICE count for related so July 3, 2011, see instructions. 8. OFFICE count for related so July 3, 2011, see instructions. 8. OFFICE count for related so July 3, 2011, see instructions. 8. OFFICE count for related so July 3, 2011, see instructions. 9. OFFICE count for related so July 3, 2011, see instructions. 9. OFFICE count for related so July 3, 2011, see instructions. 9. OFFICE count for related so July 3, 2011, see instruct	4. 00		ing period (see instru	ctions)	42. 94	4. 00
To rew programs in accordance with 42 CFR 413.79(e)	5. 00		recent cost reporting p	period ending on	0.00	5. 00
ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2)	6. 00		e criteria for an add-o	on to the cap	0.00	6. 00
If the cost report straddles July 1, 2011 then see Instructions.						
Agl Justment (Increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	7.01			(1)(1V)(B)(2)	0.00	7. 01
8. 01 The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report stradides July 1, 2011, see instructions. 8. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital 0.00 8. 02 0.00	8. 00	Adjustment (increase or decrease) to the FTE count for allopath affiliated programs in accordance with 42 CFR 413.75(b), 413.79	ic and osteopathic pro		0. 00	8. 00
B. 02	8. 01	The amount of increase if the hospital was awarded FTE cap slot	s under section 5503 or	f the ACA. If	0.00	8. 01
Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9.00 10.00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 10.00 10.00 FTE count for residents in dental and podiatric programs. 0.00 12.00 12.00 13.00 13.00 14.00	8. 02	The amount of increase if the hospital was awarded FTE cap slot	s from a closed teachi	ng hospital	0. 00	8. 02
10.00 FTE count for allopathic and osteopathic programs in the current year from your records 0.00 10.00	9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines	(8, 8,01 and 8,02) (9	see	0. 00	9. 00
12.00 Current year allowable FTE (see instructions) 0.00 12.00 13.00 10.10		FTE count for allopathic and osteopathic programs in the curren	t year from your record	ds		
14.00						
Otherwise enter zero. Sum of lines 12 through 14 divided by 3. 0.00 15.00 16		, ,				
15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 16.00 17.00 17.00 17.00 18.00 18.00 18.00 18.00 19	14. 00		ended on or after Sep	tember 30, 1997,	0. 00	14. 00
17. 00	15. 00				0. 00	15. 00
18.00 Adjusted rolling average FTE count 0.00 18.00 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 0.22.00 1 IME payment adjustment - Managed Care (see instructions) 0.22.01 1 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 0.00 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 0.00 23.00 (f)(1)(iv)(c). 0.1ME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 27.00 28.01 IME add-on adjustment amount (see instructions) 0.000000 27.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 29.01 Total IME payment - Managed Care (sum of l	16.00	Adjustment for residents in initial years of the program				
19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.0000000 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 0.22.00 IME payment adjustment - Managed Care (see instructions) 0.22.01 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 0.00 23.00 (f)(1)(iv)(C) 0.00 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 27.00 27.00 IME payments adjustment factor. (see instructions) 0.00000 27.00 28.00 IME add-on adjustment amount (see instructions) 0.00000 27.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 29.01 Total IME payment (sum of lines 22 and 28) 0.29.00 70 tal IME payment - Managed Care (sum of lines 22.01 and 28.01)			re			
20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 22.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 0.000000 21.00 0.000000 21.00 0.000000 21.00 0.000000 21.00 0.000000 21.00 0.000000 22.00 0.000000 22.00 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000						
21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00		, ,				
22.00 IME payment adjustment (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 22.01 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 26.00 IME payments adjustment factor. (see instructions) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME payments adjustment amount (see instructions) 29.00 IME add-on adjustment amount (see instructions) 20.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Sum of lines 30 and 31 30.00 Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions) 9.94 33.00		l ,				
22. 01 IME payment adjustment - Managed Care (see instructions) 1 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 24. 00 IME FTE Resident Count Over Cap (see instructions) 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see		, , , , , , , , , , , , , , , , , , ,				
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 0.00 23.00 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME payments adjustment amount (see instructions) 0.000000 27.00 IME add-on adjustment amount (see instructions) 0.000000 27.00 IME add-on adjustment amount - Managed Care (see instructions) 0.000000 27.00 IME add-on adjustment amount - Managed Care (see instructions) 0.000000 27.00 IME add-on adjustment amount - Managed Care (see instructions) 0.000000 27.00 IME add-on adjustment amount - Managed Care (see instructions) 0.000000 27.00 IME add-on adjustment amount - Managed Care (sum of lines 22.01 and 28.01) 0.000000 29.01 IME add-on adjustment - Managed Care (sum of lines 22.01 and 28.01) 0.000000 29.01 IOS IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.000000000000000000000000000000000						
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 0.00 23.00 (f) (1) (iv) (C). 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 1f the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME payments adjustment amount (see instructions) 0.000000 27.00 IME add-on adjustment amount (see instructions) 0.28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 Total IME payment (sum of lines 22 and 28) 0.29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.00 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 25.12 32.00 Sum of lines 30 and 31 25.12 32.00 33.00 Allowable disproportionate share percentage (see instructions) 9.94 33.00			n 422 of the MMA			
24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 33.00	23. 00	Number of additional allopathic and osteopathic IME FTE residen	t cap slots under 42 Se	ec. 412.105	0. 00	23. 00
instructions	24.00				0.00	24. 00
26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0 28.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0 28.01 29.00 Total IME payment (sum of lines 22 and 28) 0 29.00 29.01 Disproportionate Share Adjustment 0 29.01 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 3.03 30.00 31.00 Percentage of Medicaid patient days (see instructions) 22.09 31.00 32.00 Sum of lines 30 and 31 25.12 32.00 33.00 Allowable disproportionate share percentage (see instructions) 9.94 33.00	25. 00		wer of line 23 or line	24 (see	0.00	25. 00
27. 00 IME payments adjustment factor. (see instructions) 0.000000 27. 00 28. 00 IME add-on adjustment amount (see instructions) 0.28. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0.28. 01 29. 00 Total IME payment (sum of lines 22 and 28) 0.29. 00 29. 01 Total IME payment - Managed Care (sum of lines 22. 01 and 28. 01) 0.00000 Disproportionate Share Adjustment 99. 01 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 3. 03 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 22. 09 31. 00 32. 00 Sum of lines 30 and 31 25. 12 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 9. 94 33. 00	26 00				0.000000	26 00
28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Percentage of Medicaid patient days (see instructions) 30.00 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 30.00 Allowable disproportionate share percentage (see instructions) 30.00 Percentage of Medicaid patient days (see instructions) 30.00 Allowable disproportionate share percentage (see instructions) 30.00 Percentage of Medicaid patient days (see instructions)						
28.01 IME add-on adjustment amount - Managed Care (see instructions) 0 28.01 29.00 Total IME payment (sum of lines 22 and 28) 0 29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29.01 Disproportionate Share Adjustment 0 29.01 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 3.03 30.00 31.00 Percentage of Medicaid patient days (see instructions) 22.09 31.00 32.00 Sum of lines 30 and 31 25.12 32.00 33.00 Allowable disproportionate share percentage (see instructions) 9.94 33.00						
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 30. 01 Percentage of Medicaid patient days (see instructions) 31. 02 Percentage of Medicaid patient days (see instructions) 32. 03 Percentage of Medicaid patient days (see instructions) 33. 00 Percentage of Medicaid patient days (see instructions) 30. 00 Percentage of Medicaid patient days (see instructions) 30. 00 Percentage of Medicaid patient days (see instructions) 30. 00 Percentage of Medicaid patient days (see instructions) 30. 00 Percentage of Medicaid patient days (see instructions) 30. 00 Percentage of Medicaid patient days (see instructions) 30. 00 Percentage of Medicaid patient days (see instructions) 30. 00 Percentage of Medicaid patient days (see instructions) 30. 00 Percentage of Medicaid patient days (see instructions) 30. 00 Percentage of Medicaid patient days (see instructions)	28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	
Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 30.00 22.09 31.00 31.00 25.12 32.00 32.00 33.00 Allowable disproportionate share percentage (see instructions) 30.00 20.00 31.0	29.00	Total IME payment (sum of lines 22 and 28)			0	29. 00
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 30.00 22.09 31.00 25.12 32.00 33.00	29. 01				0	29. 01
31.00Percentage of Medicaid patient days (see instructions)22.0931.0032.00Sum of lines 30 and 3125.1232.0033.00Allowable disproportionate share percentage (see instructions)9.9433.00	30.00		ient days (see instruc	tions)	3. 03	30.00
33.00 Allowable disproportionate share percentage (see instructions) 9.94 33.00			-	•		
	32.00	Sum of lines 30 and 31			25. 12	32.00
34.00 Disproportionate share adjustment (see instructions) 214,696 34.00		, , , , , , , , , , , , , , , , , , , ,				
	34. 00	Disproportionate share adjustment (see instructions)		l	214, 696	34. 00

0

ol 70.95

82, 986

-20, 627

70.92 0

70.93

70.94

70.91

70. 92

70 93

70.94

HSP bonus payment HRR adjustment amount (see instructions)

Bundled Model 1 discount amount (see instructions)

HVBP payment adjustment amount (see instructions)

HRR adjustment amount (see instructions)

70.95 Recovery of accelerated depreciation

	Financial Systems MAJOR HOSE				u of Form CMS-2	2552-10
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0097	Peri od: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Pre 5/25/2017 11::	pared: 27 am
		Title	XVIII	Hospi tal	PPS	
			FFY	(yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		2016	193, 917	70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97				2017	23, 807	70. 97
	the corresponding federal year for the period ending on or at	fter 10/1)				
70. 98	1				0	
70. 99	HAC adjustment amount (see instructions)				0	1 , 0, , ,
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			9, 208, 764	
71. 01	Sequestration adjustment (see instructions)				184, 175	
72. 00	Interim payments				9, 003, 941	
73. 00					0	
74. 00					20, 648	
75. 00	CMS Pub. 15-2, chapter 1, §115.2	ance with			2, 013, 745	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see in	structions)			0	
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	
92. 00	1 1 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3				0	92.00
93. 00	1				0	93.00
94. 00	1				0. 00	
	Time value of money for operating expenses (see instructions)				0	95.00
96. 00	Time value of money for capital related expenses (see instruc	ctions)			0	96.00
				Prior to 10/1		
				1. 00	2. 00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)			1. 0020400000		
102.00	HVBP adjustment amount for HSP bonus payment (see instruction	ns)		0	0	102.00
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)			0. 9979	0. 9966	
104 00	HRR adjustment amount for HSP bonus payment (see instructions	s)		0	0	104.00

In Lieu of Form CMS-2552-10

Period: Worksheet E
From 01/01/2016 Part A Exhibit 4
To 12/31/2016 Date/Time Prepared: 5/25/2017 11: 27 am Provider CCN: 15-0097

					'	0 12/31/2010	5/25/2017 11:	
				_	XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Peri od Pri or	Peri od	Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	On/After 10/01 4.00	through 4) 5.00	
1. 00	DRG amounts other than outlier	1. 00	1.00	2.00	3.00		0.00	1. 00
00	payments	00	ا	J				1.00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	6, 729, 433	0	6, 729, 433		6, 729, 433	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	1, 910, 200	0		1, 910, 200	1, 910, 200	1. 02
1. 03	1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0		0	1. 03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2. 00	Outlier payments for	2. 00	99, 030	0	69, 489	29, 541	99, 030	2. 00
2. 01	discharges (see instructions) Outlier payments for	2. 02	0	0	0	0	0	2. 01
3. 00	discharges for Model 4 BPCI Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4. 00	Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
5. 00	Amount from Worksheet E, Part	ustment 21.00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0. 000000	0. 000000	0. 000000	0. 000000	0	6. 00
6. 01	instructions) IME payment adjustment for	22. 00	0	0	0	0	0	6. 01
0.01	managed care (see instructions)	22.01	Ŭ	0	O		0	0.01
	Indirect Medical Education Adju	ustment for the	Add-on for Se	ction 422 of t	he MMA			
7.00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	0	0	0	0	0	8. 00
8. 01	instructions) IME payment adjustment add on for managed care (see	28. 01	0	0	0	0	0	8. 01
9. 00	instructions) Total IME payment (sum of	29. 00	0	0	0	0	0	9. 00
9. 01	lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	О	0	0	0	0	9. 01
	Di sproporti onate Share Adjustmo	ent						
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 0994	0. 0994	0. 0994	0. 0994		10. 00
11. 00	<pre>instructions) Disproportionate share adjustment (see instructions)</pre>	34. 00	214, 696	0	167, 227	47, 469	214, 696	11. 00
11. 01	Uncompensated care payments	36. 00	326, 140	0	246, 474	79, 666	326, 140	11. 01
	Additional payment for high per	centage of ESF		di scharges		,		
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	0	12. 00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments	47. 00 48. 00	9, 279, 499 0	0 0	7, 212, 623 0	2, 066, 876 0	9, 279, 499 0	13. 00 14. 00
	(completed by SCH and MDH, small rural hospitals only.) (see instructions)							
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	9, 279, 499	0	7, 212, 623	2, 066, 876	9, 279, 499	15. 00
16. 00	Payment for inpatient program capital	50. 00	699, 242	0	544, 059	155, 183	699, 242	16. 00
17. 00	Special add-on payments for new technologies	54. 00	0	0	0	0	0	17. 00
17. 01 17. 02	Net organ aquisition cost Credits received from	68. 00	0	0	0	0	0	17. 01 17. 02
18. 00	manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see	93. 00	0	0	0	0	0	18. 00
	instructions)							

	ESINE SAESSENT SIN EXITED TO			Trovider ex		From 01/01/2016 To 12/31/2016	Part A Exhibi Date/Time Pre 5/25/2017 11:	pared:
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2. 00	3. 00	4. 00	5. 00	
19. 00	SUBTOTAL			0	7, 756, 68.	2, 222, 059	9, 978, 741	19. 00
		W/S L, line	(Amounts from					
			L)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	694, 327	0	539, 62	9 154, 698	694, 327	20.00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0		0	0	20. 01
	than outlier							
21.00	Capital DRG outlier payments	2. 00	4, 915	0	4, 43	0 485	4, 915	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0		0	0	21. 01
	outlier payments							
22. 00	Indirect medical education	5. 00	0. 0000	0.0000	0.000	0.0000		22. 00
	percentage (see instructions)							
23.00		6. 00	0	0		0	0	23. 00
	adjustment (see instructions)							
24.00	Allowable disproportionate	10. 00	0. 0000	0.0000	0.000	0.0000		24. 00
	share percentage (see							
	instructions)							
25. 00	Di sproporti onate share	11. 00	0	0		0	0	25. 00
	adjustment (see instructions)							
26. 00	Total prospective capital	12. 00	699, 242	0	544, 05	9 155, 183	699, 242	26. 00
	payments (see instructions)							
		W/S E, Part A						
		line	Part A)					
		0	1.00	2. 00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0. 02500			27. 00
28. 00	Low volume adjustment	70. 96			193, 91	7	193, 917	28. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
29. 00	Low volume adjustment	70. 97				23, 807	23, 807	29. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
100.00	Transfer low volume		Y					100. 00
	adjustments to Wkst. E, Pt. A.				l			I

 Heal th Financial
 Systems
 MAJOR HOSP

 HOSPITAL
 ACQUIRED
 CONDITION (HAC)
 REDUCTION CALCULATION EXHIBIT 5
 Provider CCN: 15-0097

Misst. E, Pt. A. From Misst. E, Pt. E, Pt. A. From Pt. A. From Misst. E, Pt. E, Pt. A. From Pt. A. From Misst. E, Pt. E, Pt. A. From Pt. A.					11	0 12/31/2016	5/25/2017 11: 3	
West E. Pt. Ail. From New York Ail. From Ail. From Period of O O O O O				Title	XVIII	Hospi tal		
1.00 DRG amounts other than outlier payments 1.00 1.00 2.00 3.00 4.00 1.00 1.00 1.00 3.00 4.00 1.00 1.00 3.00 4.00 1.00 1.00 1.00 3.00 4.00 1.00			Wkst. F. Pt.					
0			•					
1.00 DRC amounts other than outlier payments 1.00 6.729, 433 6.729, 433 1.01				A)			ŕ	
1.01 DRC amounts other than outlier payments for discharges occurring prior to to otober 1 DRC amounts other than outlier payments for discharges occurring prior to otober 1 1.02 1.910.200			0	1.00	2.00	3. 00	4. 00	
discharges occurring prior to October 1 1,910,200	1. 00	DRG amounts other than outlier payments	1. 00					1. 00
1.02 1.910.200	1.01	DRG amounts other than outlier payments for	1. 01	6, 729, 433	6, 729, 433		6, 729, 433	1. 01
di scharges occurring on or after October 1 1.03 0.0 0.0 0.0 0.0 1.03 1.03 1.03 1.05		discharges occurring prior to October 1						
1.03	1.02	DRG amounts other than outlier payments for	1. 02	1, 910, 200		1, 910, 200	1, 910, 200	1. 02
Tor Model 4 BPCI occurring prior to October 1		discharges occurring on or after October 1						
1.04 DRG for Federal specific operating payment 1.04 0 0 0 0 0 0 0 0 0	1.03	DRG for Federal specific operating payment	1. 03	0	0		0	1.03
For Model A BPCI occurring on or after		for Model 4 BPCI occurring prior to October						
For Model A BPCI occurring on or after		1						
October 1 Color	1.04	DRG for Federal specific operating payment	1. 04	0		0	0	1. 04
2.00		for Model 4 BPCI occurring on or after						
Instructions								
2.01 Special payments for discharges for Model 4 2.02 0 0 0 0 0 0 0 0 0	2.00		2. 00	99, 030	69, 489	29, 541	99, 030	2. 00
BPCI		,						
3.00 Operating outlier reconciliation 2.01 0 0 0 0 0 0 4.00	2. 01		2. 02	0	0	0	0	2. 01
Anonged care simulated payments		i i						
Indirect Medical Education Adjustment				1	_	· ·		
Amount from Worksheet E, Part A, I ine 21 21.00 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	4. 00		3. 00	0	0	0	0	4. 00
See instructions Compared to the payment adjustment (see instructions) 22.00 0 0 0 0 0 0 0 0 0								
6.00 IME payment adjustment (see instructions) 22.00 0 0 0 0 0 6.00	5. 00		21. 00	0. 000000	0. 000000	0. 000000		5. 00
IME payment adjustment for managed care (see 22.01 0 0 0 0 0 6.01				_	_	_	_	
Instructions								
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA The payment adjustment factor (see	6. 01		22. 01	0	0	0	0	6. 01
The payment adjustment factor (see 27.00 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.0000000 0.0000000 0.000000 0.00000000								
Instructions IME adjustment (see instructions) 28.00 0 0 0 0 0 0 8.00	7.00					0.00000		7.00
8.00 IME adjustment (see instructions) 28.00 0 0 0 0 0 8.00 8.01 IME payment adjustment add on for managed 28.01 0 0 0 0 0 0 8.01 9.00 Total IME payment (sum of lines 6 and 8) 29.00 0 0 0 0 0 0 0 9.01 Total IME payment for managed care (sum of lines 6.01 and 8.01) 0 0 0 0 0 0 0 10 Disproportionate Share Adjustment 0 0 0 0 0 0 0 10 Disproportionate Share Adjustment 0 0 0 0 0 0 0 10 Disproportionate Share adjustment (see 34.00 214.696 167.227 47.469 214.696 11.00 11 10 Instructions 0 0 0 0 0 0 11 10 Instructions 0 0 0 0 0 0 12 13 0 0 0 0 0 0 13 0 0 0 0 0 0 0 14 0 0 0 0 0 0 0 15 0 0 0 0 0 0 0 16 0 0 0 0 0 0 0 17 0 0 0 0 0 0 0 18 0 0 0 0 0 0 19 0 0 0 0 0 0 10 0 0 0 0 0 0 10 0 0 0 0 0 0 10 0 0 0 0 0 11 0 0 0 0 0 0 12 0 0 0 0 0 0 13 0 0 0 0 0 0 0 14 0 0 0 0 0 0 15 0 0 0 0 0 0 16 0 0 0 0 0 0 17 0 0 0 0 0 0 18 0 0 0 0 0 0 19 0 0 0 0 0 10 0 0 0 0 0 10 0 0 0 0 0 10 0 0 0 0 0 10 0 0 0 0 0 11 0 0 0 0 0 12 0 0 0 0 0 13 0 0 0 0 0 14 0 0 0 0 0 15 0 0 0 0 0 0 16 0 0 0 0 0 0 17 0 0 0 0 0 0 18 0 0 0 0 0 0 19 0 0 0 0 0 0 10 0 0 0 0 0 10 0 0 0 0 0 11 0 0 0 0 0 12 0 0 0 0 0 13 0 0 0 0 0 14 0 0 0 0 0 0 15 0 0 0 0 0 16 0 0 0 0 0 17 0 0 0 0 0 18 0 0 0 0 0 19 0 0 0 0 0 10 0 0 0 0	7.00		27.00	0.000000	0.000000	0.000000		7.00
IME payment adjustment add on for managed care (see instructions) 29.00 0 0 0 0 0 0 0 0 0	0 00		20.00		0	0		0.00
Care (see instructions)						· ·		
9.00 Total IME payment (sum of lines 6 and 8) 29.00 0 0 0 0 0 0 0 9.01 Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage (see instructions) 11.01 Disproportionate share adjustment (see 34.00 214,696 167,227 47,469 214,696 11.00 instructions) 11.01 Uncompensated care payments 36.00 326,140 246,474 79,666 326,140 11.01 11.01 Disproportionate share adjustment (see 34.00 326,140 246,474 79,666 326,140 11.00 instructions) 12.00 Total ESRD additional payment for high percentage of ESRD beneficiary discharges 13.00 Subtotal (see instructions) 14.00 Hospital specific payments (completed by SCH 48.00 0 0 0 0 0 0 12.00 instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient operating costs (see instructions) 17.01 Disproportionate share adjustment (see 34.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8.01		28.01	0	U	U	U	8.01
9.01 Total IME payment for managed care (sum of I nes 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage (see instructions) 11.00 Disproportionate share adjustment (see 34.00 214,696 167,227 47,469 214,696 11.00 instructions) 11.01 Disproportionate share adjustment (see 34.00 326,140 246,474 79,666 326,140 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46.00 0 0 0 0 12.00 instructions) 13.00 Subtotal (see instructions) 47.00 9,279,499 7,212,623 2,066,876 9,279,499 13.00 14.00 Hospital specific payments (completed by SCH 48.00 0 0 0 0 0 14.00 and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs 49.00 9,279,499 7,212,623 2,066,876 9,279,499 15.00 (see instructions) 16.00 Payment for inpatient program capital 50.00 699,242 544,059 155,183 699,242 16.00 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 68.00 0 0 0 0 0 0 17.02 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 0 0 18.00 18.00	0.00		20.00		0	0		0.00
I ines 6.01 and 8.01 Disproportionate Share Adjustment					0	0	-	
Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.0994 0.0994 0.0994 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 214,696 167,227 47,469 214,696 11.00 instructions) 11.01 Uncompensated care payments 36.00 326,140 246,474 79,666 326,140 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46.00 0 0 0 0 0 12.00 instructions) 13.00 Subtotal (see instructions) 47.00 9,279,499 7,212,623 2,066,876 9,279,499 13.00 14.00 and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs 49.00 9,279,499 7,212,623 2,066,876 9,279,499 15.00 (see instructions) 15.00 Payment for inpatient operating costs 49.00 9,279,499 7,212,623 2,066,876 9,279,499 15.00 (see instructions) 16.00 Payment for inpatient program capital 50.00 699,242 544,059 155,183 699,242 16.00 17.00 Net organ acquisition cost 17.01 Net organ acquisition cost 17.01 17.02 Credits received from manufacturers for 68.00 0 0 0 0 0 0 17.00 17.00 18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 0 0 18.00	9.01		29.01	0	U	U	U	9.01
10.00 Allowable disproportionate share percentage (see instructions) 11.00 Disproportionate share adjustment (see 34.00 214,696 167,227 47,469 214,696 11.00								
11.00 Disproportionate share adjustment (see 34.00 214,696 167,227 47,469 214,696 11.00 11.00 11.01 12.00 10.00 12.0	10 00		33 00	0 0994	0.0994	0.0994		10 00
11. 00 Disproportionate share adjustment (see instructions) 11. 01 Uncompensated care payments 12. 00 Total ESRD additional payment (see instructions) 13. 00 Subtotal (see instructions) 14. 00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15. 00 Total payment for inpatient operating costs (see instructions) 16. 00 Payment for inpatient program capital payment for inpatient program capital payment for new technologies 54. 00 17. 00 Special add-on payments for new technologies 54. 00 17. 00 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18. 00 Capital outlier reconciliation adjustment 93. 00 10 214, 696 16, 727 497 47, 469 214, 696 11. 00 246, 474 79, 666 326, 140 11. 01 246, 474 79, 666 326, 140 11. 01 246, 474 79, 666 326, 140 11. 01 246, 474 79, 666 326, 140 11. 01 246, 474 79, 666 326, 140 11. 01 246, 474 79, 666 326, 140 11. 01 246, 474 79, 666 326, 140 11. 01 246, 474 79, 666 326, 140 11. 01 246, 474 79, 666 326, 140 11. 01 246, 474 79, 666 326, 140 11. 01 246, 474 79, 666 326, 140 11. 01 246, 474 79, 666 326, 140 11. 01 246, 474 79, 666 326, 140 11. 01 246, 474 79, 666 326, 140 11. 01 246, 474 79, 666 326, 140 11. 01 246, 474 79, 666 326, 140 11. 01 246, 474 79, 666 326, 140 11. 01 246, 474 79, 666 326, 140 11. 01 246, 474 79, 666 326, 140 11. 01 246, 474 79, 666 326, 140 11 246, 474 79, 666 326, 140 11 246, 474 79, 666 326, 140 11 246, 474 79, 666 326, 140 11 246, 474 79, 666 326, 140 11 246, 474 79, 666 326, 140 11 246, 474 79, 666 326, 140 11 246, 474 79, 666 326, 140 11 246, 474 79, 666 326, 140 11 246, 474 79, 666 326, 140 11 246, 474 79, 666 326, 140 11 246, 474 79, 666 326, 140 11 246, 474 79, 666 326, 140 11 246, 474 47, 49 246, 474 79, 666 326, 140 11 246, 474 47, 479, 666 326, 140 11 246, 474 47, 479, 666 326, 140 11 246, 474 47, 479, 666 326, 140 11 246, 474 47, 479, 666 326, 140 11 246, 474 47, 479, 666 326, 140 11 246, 474 47, 479, 666 326, 140 11 246, 474 47, 479, 666 326, 140 11 246, 474 47, 479, 666 326	10.00		33.00	0.0774	0.0774	0.0774		10.00
11. 01 Uncompensated care payments 36. 00 326, 140 246, 474 79, 666 326, 140 11. 01	11 00		34 00	214 696	167 227	47 469	214 696	11 00
11.01 Uncompensated care payments 36.00 326,140 246,474 79,666 326,140 11.01			01.00	2.1,0,0	107,1227	177 107	211,070	
Additional payment for high percentage of ESRD beneficiary discharges Total ESRD additional payment (see 46.00 0 0 0 0 0 12.00	11. 01		36.00	326, 140	246, 474	79, 666	326, 140	11. 01
12.00 Total ESRD additional payment (see 46.00 0 0 0 0 0 12.00 instructions) 13.00 Subtotal (see instructions) 47.00 9,279,499 7,212,623 2,066,876 9,279,499 13.00 14.00 Hospital specific payments (completed by SCH 48.00 0 0 0 0 14.00 and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs 49.00 9,279,499 7,212,623 2,066,876 9,279,499 15.00 (see instructions) 16.00 Payment for inpatient program capital 50.00 699,242 544,059 155,183 699,242 16.00 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 0 18.00			D beneficiary					
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15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital 17.00 Special add-on payments for new technologies 17.01 Net organ acquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 17.01 Total payment for inpatient operating costs 49.00 9, 279, 499 7, 212, 623 2, 066, 876 9, 279, 499 15.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		and MDH, small rural hospitals only.) (see						
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17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17.00 17.01 Net organ acquisition cost 0 0 0 0 0 17.01 17.01 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 93.00 0 0 0 0 18.00								
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replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 93.00 0 0 18.00	17. 01							17. 01
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amount (see instructions)								
	18. 00		93.00	0	0	0	0	18. 00
19. 00 SUBTOTAL 7, 756, 682 2, 222, 059 9, 978, 741 19. 00								
	19. 00	SUBTOTAL			7, 756, 682	2, 222, 059	9, 978, 741	19. 00

			II TI e	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from				
			Wkst. L)				
		0	1.00	2.00	3. 00	4. 00	
20. 00	Capital DRG other than outlier	1.00	694, 327	539, 629	154, 698	694, 327	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	4, 915	4, 430	485	4, 915	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	0	0	21. 01
22. 00	Indirect medical education percentage (see	5. 00	0.0000	0.0000	0.0000		22. 00
	instructions)						
23.00	Indirect medical education adjustment (see	6. 00	0	0	0	0	23. 00
	instructions)						
24.00	Allowable disproportionate share percentage	10.00	0.0000	0.0000	0.0000		24. 00
	(see instructions)						
25.00	Di sproporti onate share adjustment (see	11. 00	0	0	0	0	25. 00
	instructions)						
26.00	Total prospective capital payments (see	12.00	699, 242	544, 059	155, 183	699, 242	26. 00
	instructions)						
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)				
		0	1. 00	2. 00	3. 00	4. 00	
27.00							27. 00
28.00	Low volume adjustment prior to October 1	70. 96	193, 917	193, 917		193, 917	28. 00
29.00	Low volume adjustment on or after October 1	70. 97	23, 807		23, 807	23, 807	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	82, 986	65, 819	17, 167	82, 986	30.00
30. 01	HVBP payment adjustment for HSP bonus	70. 90	0	0	0	0	30. 01
	payment (see instructions)						
31.00	HRR adjustment (see instructions)	70. 94	-20, 627	-14, 132	-6, 495	-20, 627	31.00
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	0	0	0	0	31. 01
	instructions)						
						(Amt. to Wkst.	
						E, Pt. A)	
		0	1. 00	2. 00	3. 00	4. 00	
32.00	HAC Reduction Program adjustment (see	70. 99		0	0	0	32. 00
	instructions)						
100.00	Transfer HAC Reduction Program adjustment to		N				100. 00
	Wkst. E, Pt. A.						

Health Financial Systems	MAJOR HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0097	Peri od: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/25/2017 11: 27 am

PRESENCE PRESENCE PRESENCE PRESENCE PRESENCE				10 12/31/2016	5/25/2017 11:	pared: 27 am
Description			Title XVIII	Hospi tal		27 4111
Medical and other services (see instructions) 3,99						
Medical and other services (see instructions) 3,97		DADT D. MEDICAL AND OTHER HEALTH CERVILORS			1. 00	
	1 00				2 006	1.00
3.00 PSp payments		,	tions)			
4.00 Outlier payment (see Instructions) 6.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Enter the hospital specific payment to cost ratio (see instructions) 7.00 Sum of Time 3 plus line 4 divided by line 6 8.00 Interest the hospital specific payment (see instructions) 8.00 Ancil Intry service other pass through costs from West. D. Pt. IV. col. 13. line 200 8.01 Intrastitional corridor payment (see instructions) 8.02 Ancil Intry service other pass through costs from West. D. Pt. IV. col. 13. line 200 8.03 Intry service other pass through costs from West. D. Pt. IV. col. 13. line 200 8.04 Ancil Intry service other pass through costs from West. D. Pt. IV. col. 13. line 200 8.05 Ancil Intry service charges 8.05 Intry service charges 8.06 Ancil Intry service charges 8.07 Intry service charges 9.12.00 Ancil Intro services on a charge basis in 11. 77 9.07 Introduction of the services on a charge basis in 11. 77 9.08 Ancil Introduction of the services on a charge basis in 11. 77 9.08 Excess of introduction of the services on a charge basis in 11. 77 9.09 Excess of customary charges (see instructions) 9.00 Excess of customary charges (see instructions) 11. 70 Excess of customary charges (see instructions) 12. 80 Excess of customary charges (see instructions) 13. 90 Excess of customary charges (see instructions) 14. 90 Excess of customary charges (see instructions) 15. 90 Excess of customary charges (see instructions) 16. 90 Excess of customary charges (see instructions) 17. 90 Excess of customary charges (see instructions) 18. 90 Excess of customary charges (see instructions) 19. 90 Excess of customary charges over reasonable cost (complete only if line 11 exceeds line 18		· ·	ti ons)			
Enter the hospital specific payment to cost ratio (see instructions) Enter time from the foliation of control of the specific payment to cost ratio (see instructions) Sum of line 3 plus line 4 divided by line 6 Olians 2 times line 5 Control of line 3 plus line 4 divided by line 6 Olians 2 times line 5 Control of line 3 plus line 4 divided by line 6 Olians 2 times line 5 Control of line 3 plus line 4 divided by line 6 Olians 2 times line 5 Control of line 3 plus line 4 divided by line 6 Olians 3 times 2 times 1 and 10) (see instructions) Control of line 3 plus line 5 times 1 and 10) (see instructions) Control of line 3 line 5 times 1 and 10) (see instructions) Control of line 5 line 5 times 1 and 10) (see instructions) Control of line 5 line 5 times 1 line 5 line 1 line 5 line 6 lin		. 3			47, 914	
Line 2 times line 5 Line 2 times line 5 Line 3 pus line 4 divided by line 6 Composition of times a pus line 4 divided by line 6 Line 3 times line 3 pus line 4 divided by line 6 Line 3 times line 3 pus line 4 divided by line 6 Line 1 times and restrictions Line 2 times line 3 pus line 4 divided by line 6 Line 3 pus line 4 divided by line 6 Line 2 times line 3 pus line 4 divided by line 6 Line 2 times line 3 pus line 4 divided by line 6 Line 2 times line 3 pus line 4 divided by line 6 Line 2 times line 3 pus line 4 divided by line 6 Line 2 times line 3 pus line 4 divided by line 6 Line 2 times line 3 pus line 4 divided by line 6 Line 2 times line 3 pus line 4 divided by line 6 Line 2 times line 3 pus line 4 divided by line 6 Line 2 times line 3 pus line 4 divided by line 6 Line 2 times line 3 pus line 4 divided by line 6 Line 2 times line 3 pus line 4 divided by line 6 Line 2 times line 3 pus line 4 divided by line 6 Line 2 times line 3 pus line 4 divided by line 6 Line 2 times line 4 pus line 4 divided by line 6 Line 2 times line 4 pus line 4 divided by line 6 Line 2 times line 4 pus line 4 divided by line 6 Line 2 times line 4 pus line 4 divided by line 6 Line 2 times line 4 pus line 4 divided by line 6 Line 2 times line 4 pus line 4 divided by line 6 Line 2 times line 4 pus line 4 divided by line 6 Line 2 times line 4 pus line 4 divided by line 6 Line 2 times line 4 pus line 4 divided by line 6 Line 2 times line 4 pus line 4 divided by line 6 Line 2 times line 4 pus line 4 divided by line 6 Line 2 times line 4 pus line 4 divided by line 6 Line 2 times line 4 pus line 4 divided by line 6 Line 2 times line 4 pus line 4 divided by line 6 Line 2 times line 4 pus line 4 divided by line 6 Line 2 times line 4 pus line 4 divided by line 6 Line 2 times line 4 pus line 4 divided by line 6 Line 2 times line 4 pus line 4 divided by line 6 pus line 6 pus line 6 Line 2 times line 4 pus line 4 pus line 4 pus line 6 Line 2 times line 4 pus line 4 pus line 6 Line 2 times line 4 pus lin		, ,	ctions)		0.000	
Transitional corridor payment (see instructions) 7 Transitional corridor payment (see instructions) 7 April 1979 service other pass through costs from Wkst. D. Pt. IV. col. 13. Iline 200 7 Organ acquisitions 7 Organ acquisitions 7 Organ acquisitions 8 Reasonable charges Re	6. 00		•		0	1
Ancil lary service other pass through costs from West. D. Pt. IV, col. 13, line 200	7. 00	Sum of line 3 plus line 4 divided by line 6			0.00	7.0
0.00 Organ acquisitions 1.00 (organ acquisitions) 3.99 1.00 Organ acquisition of LESSER OF COST OR CHARGES Reasonable reasonable cost countries in paintenties Reasonable charges Reasonable charges Reasonable charges Reasonable charges Reaso	8. 00	Transitional corridor payment (see instructions)			0	8. 0
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Pioneer ACO demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) 11 Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{115}{215}.2\$ TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 7. 429, 05 7. 420					-58	38. 0 39. 0
Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) For the payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) For tested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115. 2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money Occupance of the visual devices (see instructions) 7, 429, 05. 148, 58 7, 284, 79 148, 58 7, 284, 79 148, 58 7, 284, 79 148, 58 7, 284, 79 158, 158, 2 169, 100 To BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions) On the rate used to calculate the Time Value of Money On the contractors (see instructions)		, , ,	s)		0	1
RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) 7, 429, 05 40. 01 Sequestration adjustment (see instructions) 1148, 58 41. 00 Interim payments 7, 284, 79 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115. 2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 0. 00		1 3 3 1		tions)	0	1
40.00 Subtotal (see instructions) 7, 429, 05 40.01 Sequestration adjustment (see instructions) 1148, 58 41.00 Interim payments 7, 284, 79 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money 7, 429, 05 148, 58 7, 284, 79 16 17 18 19 19 10 10 11 11 11 11 11 11 11 11 11 11 11		·	ded devices (see Thisti de	(10113)	0	1
40.01 Sequestration adjustment (see instructions) Interim payments 7, 284, 794 7					-	1
#1.00 Interim payments 7, 284, 790 12.00 Tentative settlement (for contractors use only) 13.00 Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions) Outlier rate used to calculate the Time Value of Money 7, 284, 790 -4, 31 -4, 3					148, 581	1
Hand the second		•			7, 284, 790	41.0
Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2 TO BE COMPLETED BY CONTRACTOR On 00 Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions) On the rate used to calculate the Time Value of Money On 00 Original outlier amount (see instructions) On 01 Original outlier amount (see instructions) On 02 Original outlier amount (see instructions) On 03 Original outlier amount (see instructions) On 04 Original outlier amount (see instructions) On 05 Original outlier amount (see instructions) On 06 Original outlier amount (see instructions) On 07 Original outlier amount (see instructions)	12. 00	Tentative settlement (for contractors use only)			0	42.0
§115. 2 TO BE COMPLETED BY CONTRACTOR On 00 Original outlier amount (see instructions) On 1.00 Outlier reconciliation adjustment amount (see instructions) On 1.00 The rate used to calculate the Time Value of Money On 0.00		1 1 3 1			-4, 315	1
TO BE COMPLETED BY CONTRACTOR On 00 Original outlier amount (see instructions) On 00 Outlier reconciliation adjustment amount (see instructions)	14. 00		nce with CMS Pub. 15-2,	chapter 1,	0	44.0
00.00 Original outlier amount (see instructions) 01.00 Outlier reconciliation adjustment amount (see instructions) 02.00 The rate used to calculate the Time Value of Money 0.00						-
01.00 Outlier reconciliation adjustment amount (see instructions) 02.00 The rate used to calculate the Time Value of Money 0.00	00.00				_	00.0
22.00 The rate used to calculate the Time Value of Money 0.00		· · · · · · · · · · · · · · · · · · ·			0	
						91. 0 92. 0
75. UU TITIIIE VALUE OL MONEV (SEE ENSTRUCTIONS)		Time Value of Money (see instructions)			0.00	1
		· · · · · · · · · · · · · · · · · · ·				94. 0

Peri od: Worksheet E-1
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared: 5/25/2017 11: 27 am Provider CCN: 15-0097

					5/25/2017 11: 2	27 am
			XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	⁻t 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		8, 924, 752		7, 064, 897	1. 00
2.00	Interim payments payable on individual bills, either		C)	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	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) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	12/31/2016	24, 889	12/31/2016	174, 293	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER	09/23/2016	54, 300		45, 600	3. 02
3. 03		0772072010	01,000		0	3. 03
3. 04			ď		0	3. 04
3. 05			Ö		l ol	3. 05
	Provider to Program		_			
3.50	ADJUSTMENTS TO PROGRAM		C)	0	3. 50
3.51			C)	0	3. 51
3.52			C)	0	3. 52
3.53			C)	0	3. 53
3.54			C)	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		79, 189		219, 893	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		9, 003, 941		7, 284, 790	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider				,	
5.01	TENTATI VE TO PROVI DER		C)	0	5. 01
5.02			C)	0	5. 02
5.03			C)	0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51			C		0	5. 51
5. 52			C		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C)	0	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		20, 648	3	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		20, 040		4, 315	6. 02
7. 00	Total Medicare program liability (see instructions)		9, 024, 589		7, 280, 475	7. 00
	, , , , , , , , , , , , , , , , , , , ,		., == ., 00,	Contractor	NPR Date	., 30
				Number	(Mo/Day/Yr)	
				Trainio O I	()	
8.00	Name of Contractor	()	1. 00	2. 00	8. 00

Heal th	Financial Systems MAJO	OR HOSPITAL	In Lie	u of Form CMS-2	2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0097	Peri od:	Worksheet E-1		
			From 01/01/2016 To 12/31/2016		oorod:	
			10 12/31/2016	5/25/2017 11:		
		Title XVIII	Hospi tal	PPS		
			'			
				1. 00		
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS						
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCU	JLATI ON				
1.00	Total hospital discharges as defined in AARA §4102 from	m Wkst. S-3, Pt. I col. 15 line	14	2, 793	1.00	
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of line	es 1, 8-12		4, 771	2.00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	2		1, 376	3.00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of line	es 1, 8-12		10, 419	4.00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line	200		292, 682, 177	5.00	
6.00	Total hospital charity care charges from Wkst. S-10, co	ol. 3 line 20		2, 827, 465	6.00	
7.00	CAH only - The reasonable cost incurred for the purchas	se of certified HIT technology	Wkst. S-2, Pt. I	0	7. 00	
	line 168					
8.00	Calculation of the HIT incentive payment (see instructi	ons)		0	8. 00	
9.00	Sequestration adjustment amount (see instructions)			0	9.00	
10.00	Calculation of the HIT incentive payment after sequestr	ration (see instructions)		0	10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instruction	ns)		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 instruction	s)	0	32.00	

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

0 30.00 0 31.00 0 32.00

Health Financial Systems	MAJOR HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0097	Peri od:	Worksheet E-3
		From 01/01/2016	

			To 12/31/2016	Date/Time Pre 5/25/2017 11:	
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	S FOR TITLES V OR XI	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		814, 733		1.00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		814, 733	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6. 00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		814, 733	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8. 00	Routine service charges		677, 306		8. 00
9.00	Ancillary service charges		1, 396, 755	0	
10.00	Organ acquisition charges, net of revenue		0		10.00
	Incentive from target amount computation		2, 074, 061	0	11. 00 12. 00
12.00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		2,074,061	U	12.00
13. 00	Amount actually collected from patients liable for payment for ser	cylicos on a chargo	0	0	13. 00
13.00	basis	vices on a charge	١	Ü	13.00
14. 00	Amounts that would have been realized from patients liable for pay	vment for services on	o	0	14. 00
14.00	a charge basis had such payment been made in accordance with 42 CF		Ĭ	O	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	3	0. 000000	0.000000	15. 00
16.00			2, 074, 061	0	16. 00
17.00	Excess of customary charges over reasonable cost (complete only if	fline 16 exceeds	1, 259, 328	0	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only if	fline 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	
20.00	Cost of physicians' services in a teaching hospital (see instructi	ons)	0	0	1
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		814, 733	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be comp	oleted for PPS provide			
	Other than outlier payments		0	0	
	Outlier payments		0	0	23. 00
	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0	0	25. 00
26. 00 27. 00	Routine and Ancillary service other pass through costs		0	0	26. 00 27. 00
28. 00	Subtotal (sum of lines 22 through 26) Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		814, 733	0	
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		014, 733	0	29.00
30. 00	Excess of reasonable cost (from line 18)		O	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		814, 733	0	
32. 00	Deductibles		011,700	0	
33. 00	Coinsurance		0	0	1
	Allowable bad debts (see instructions)		o	0	34.00
	Utilization review		o	_	35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33))	814, 733	0	36. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38.00	Subtotal (line 36 ± line 37)		814, 733	0	38. 00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	814, 733	0	40. 00	
41.00	Interim payments		901, 900	0	41. 00
42.00	Balance due provider/program (line 40 minus line 41)		-87, 167	0	42. 00
43.00	Protested amounts (nonallowable cost report items) in accordance w	0	0	43. 00	
	chapter 1, §115.2				l

Health Financial Systems MAJOR BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column onl y)

Peri od: Worksheet G From 01/01/2016 To 12/31/2016 Date/Time Prepared:

onl y)			'	0 12/31/2010	5/25/2017 11:	
		General Fund	Speci fi c	Endowment Fund		
		1. 00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3, 589, 642	2 C	-	0	1.00
2. 00 3. 00	Temporary investments Notes receivable			-	0	2. 00 3. 00
4. 00	Accounts receivable	27, 661, 200	1	0	0	4.00
5. 00	Other recei vabl e	27,001,200	ol o	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-18, 800, 918	3 0	0	0	6. 00
7.00	Inventory	2, 476, 363	B C	0	0	7. 00
8.00	Prepai d expenses	0) c	0	0	8. 00
9.00	Other current assets	13, 058, 247		0	0	9. 00
10.00	Due from other funds	07.004.504			0	10.00
11. 00	Total current assets (sum of lines 1-10)	27, 984, 534	<u> </u>	0	0	11. 00
12. 00	FI XED ASSETS Land	1, 978, 356		O	0	12. 00
13. 00	Land improvements	6, 109, 252	1	-	0	13. 00
14. 00	Accumul ated depreciation	-2, 431, 621	1		0	14. 00
15.00	Bui I di ngs	141, 903, 904	1	0	0	15. 00
16. 00	Accumulated depreciation	-25, 542, 201	C	0	0	16. 00
17. 00	Leasehold improvements	526, 503	1	0	0	17. 00
18.00	Accumulated depreciation	-493, 494	1		0	18.00
19.00	Fixed equipment	349, 773	1	-	0	19.00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks			0	0	20. 00 21. 00
22. 00	Accumul ated depreciation	0		0	0	22.00
23. 00	Major movable equipment	34, 989, 163	s o	Ö	0	23. 00
24. 00	Accumul ated depreciation	-27, 302, 726	1	0	0	24. 00
25.00	Mi nor equi pment depreci abl e	0) c	0	0	25. 00
26. 00	Accumul ated depreciation	0) c	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0		0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	120 004 000	0	-	0	29.00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	130, 086, 909	<u>'</u>	U	0	30.00
31. 00	Investments	0		0	0	31.00
32.00	Deposits on Leases	O) c	0	0	32.00
33.00	Due from owners/officers	0) c	0	0	33. 00
34.00	Other assets	127, 726, 408	1	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	127, 726, 408			0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	285, 797, 851	C	0	0	36. 00
37. 00	CURRENT LIABILITIES Accounts payable	6, 020, 475	i c	O	0	37. 00
38. 00	Salaries, wages, and fees payable	8, 496, 437	1	0	0	38.00
39. 00	Payroll taxes payable	0, 170, 107		Ö	0	39. 00
40.00	Notes and Loans payable (short term)	O	0	0	0	40. 00
41.00	Deferred income	0) c	0	0	41.00
42.00	Accel erated payments	0				42. 00
43.00	Due to other funds	0	0	0	0	43.00
44. 00 45. 00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	4, 493, 284 19, 010, 196			0	
45.00	LONG TERM LIABILITIES	19,010,190	<u> </u>	U U	0	45.00
46. 00	Mortgage payable	0	ol c	0	0	46. 00
47. 00	Notes payable	O		0	0	47. 00
48.00	Unsecured Loans	0) c	0	0	48. 00
49.00	Other long term liabilities	78, 224, 292		0	0	49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49)	78, 224, 292	1		0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	97, 234, 488	B C	0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	188, 563, 363	ol .			52. 00
53. 00	Specific purpose fund	100, 303, 303) (53.00
54. 00	Donor created - endowment fund balance - restricted		1	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,				0	58. 00
E0 00	replacement, and expansion	100 5/2 2/2	,		_	E0 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	188, 563, 363 285, 797, 851	1	0	0	59. 00 60. 00
00.00	[59]	200, 171, 001				00.00
		1	1	1	ı	'

Provider CCN: 15-0097

					То	12/31/2016	Date/Time Prep 5/25/2017 11:	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	_ / Gill
1.00	Te did di	1.00	2.00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		147, 695, 733			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		40, 785, 047			0		2.00
3.00	Total (sum of line 1 and line 2) CONTRACTUALS REPORTED AS EXP	82, 583	188, 480, 780		0	U	0	3. 00 4. 00
4. 00 5. 00	CUNTRACTUALS REPORTED AS EXP	82, 383			0		0	4. 00 5. 00
6. 00		0			0		0	6. 00
7. 00		0			0		0	7. 00
8. 00		0			0		Ö	8. 00
9. 00		0			0		0	9. 00
10. 00	Total additions (sum of line 4-9)		82, 583			ol	, and the second	10. 00
11. 00	Subtotal (line 3 plus line 10)		188, 563, 363			ol		11. 00
12. 00	Deductions (debit adjustments) (specify)	o			0	آ ۔	0	12. 00
13. 00	, , , , , , , , , , , , , , , , , , ,	O			0		0	13.00
14.00		O			0		0	14.00
15.00		0			0		0	15.00
16.00		0			0		0	16.00
17. 00		0			0		0	17.00
18. 00	Total deductions (sum of lines 12-17)		0			0		18.00
19. 00	Fund balance at end of period per balance		188, 563, 363			0		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund				
		Lildowillett Turid	Frant	Tuliu				
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1. 00
		1 9			U			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				U			2. 00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	0			0			
2. 00 3. 00 4. 00		0	0					2. 00
2.00 3.00 4.00 5.00	Total (sum of line 1 and line 2)	0	0					2. 00 3. 00 4. 00 5. 00
2.00 3.00 4.00 5.00 6.00	Total (sum of line 1 and line 2)	0	0 0 0					2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Total (sum of line 1 and line 2)	0	0 0 0					2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Total (sum of line 1 and line 2)	0	0 0 0 0					2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Total (sum of line 1 and line 2) CONTRACTUALS REPORTED AS EXP	0	0 0 0 0 0		0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Total (sum of line 1 and line 2) CONTRACTUALS REPORTED AS EXP Total additions (sum of line 4-9)	0	0 0 0 0 0		0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Total (sum of line 1 and line 2) CONTRACTUALS REPORTED AS EXP Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0	0 0 0 0 0		0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Total (sum of line 1 and line 2) CONTRACTUALS REPORTED AS EXP Total additions (sum of line 4-9)	0	0 0 0 0 0		0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Total (sum of line 1 and line 2) CONTRACTUALS REPORTED AS EXP Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0 0	0 0 0 0 0		0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Total (sum of line 1 and line 2) CONTRACTUALS REPORTED AS EXP Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0 0	0 0 0 0 0 0		0			2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	Total (sum of line 1 and line 2) CONTRACTUALS REPORTED AS EXP Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0 0	0 0 0 0 0 0		0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Total (sum of line 1 and line 2) CONTRACTUALS REPORTED AS EXP Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0 0	0 0 0 0 0 0		0			2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Total (sum of line 1 and line 2) CONTRACTUALS REPORTED AS EXP Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0 0	0 0 0 0 0 0 0		0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total (sum of line 1 and line 2) CONTRACTUALS REPORTED AS EXP Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0	0 0 0 0 0 0		0 0 0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total (sum of line 1 and line 2) CONTRACTUALS REPORTED AS EXP Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	0000	0 0 0 0 0 0		0 0 0			2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0097

			0 12/31/2016	Date/IIme Prep 5/25/2017 11::	
	Cost Center Description	Inpatient	Outpati ent	Total	
	·	1.00	2.00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	18, 094, 161		18, 094, 161	1.00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF	C		0	3. 00
4.00	SUBPROVI DER	C		0	4. 00
5.00	Swing bed - SNF	C		0	5. 00
6.00	Swing bed - NF			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)	18, 094, 161		18, 094, 161	10. 00
	Intensive Care Type Inpatient Hospital Services		T		
11. 00	INTENSIVE CARE UNIT	4, 107, 091		4, 107, 091	11. 00
12. 00	CORONARY CARE UNIT				12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL INTENSI VE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of line	es 4, 107, 091		4, 107, 091	16. 00
47.00	11-15)	00 004 050		00 004 050	47.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	22, 201, 252		22, 201, 252	17. 00
18.00	Ancillary services	47, 144, 835		223, 940, 265	18.00
19. 00	Outpatient services	6, 433, 512		44, 290, 608	
20.00	RURAL HEALTH CLINIC	C		0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	C		0	21. 00
22. 00	HOME HEALTH AGENCY		2, 250, 052	2, 250, 052 0	22. 00
23. 00 24. 00	AMBULANCE SERVICES CMHC	١ ٠ ٠	U U	U	23. 00 24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPICE				26. 00
27. 00	MHCD	1, 314, 870	4, 321, 541	5, 636, 411	27. 00
27. 00	HOSPI TALI ST	2, 040, 699		2, 931, 171	27. 00
27. 01	OTHER NONREIMBURSABLE COST CENTERS	4, 210		1, 560, 452	
27. 02	PRO FEES	1, 507, 628		4, 034, 404	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to W			306, 844, 615	28. 00
20.00	G-3, line 1)	00, 047, 000	220, 177, 007	300, 044, 013	20.00
	PART II - OPERATING EXPENSES	'			
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		99, 312, 841		29. 00
30.00	ADD (SPECIFY)				30. 00
31.00		l c			31.00
32.00					32.00
33.00					33. 00
34.00					34.00
35.00					35. 00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	c			37.00
38. 00		c			38. 00
39. 00		c			39. 00
40.00		c			40.00
41.00		c			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)(tr	ansfer	99, 312, 841		43. 00
	to Wkst. G-3, line 4)				

Heal th	Financial Systems MAJOR HOSP	ΡΙΤΑΙ	In lie	u of Form CMS-2	2552-10
	MENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0097	Peri od:	Worksheet G-3	
		1	From 01/01/2016		
			To 12/31/2016	Date/Time Pre	
				5/25/2017 11:	27 am
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir	ne 28)		306, 844, 615	1, 00
2. 00	Less contractual allowances and discounts on patients' accour	204, 284, 911			
3. 00	Net patient revenues (line 1 minus line 2)	102, 559, 704	3. 00		
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		99, 312, 841	ł
5. 00	Net income from service to patients (line 3 minus line 4)	,		3, 246, 863	•
	OTHER I NCOME			0,2.0,000	
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			4, 555, 460	7. 00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking Lot receipts			0	12. 00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other t	than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17. 00
18. 00	Revenue from sale of medical records and abstracts			0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00	RENTAL I NCOME			3, 947, 106	24. 00
24. 01	INTEREST INCOME			1, 054, 690	24. 01
24. 02	OTHER NON OPERATING INCOME			27, 980, 928	24. 02
25 00	Total other income (sum of lines 6.24)			27 520 104	25 00

24.02 Other NON OPERATING INCOME
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 OTHER EXPENSES (SPECIFY)
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

25.00

26.00 27. 00 28. 00 0 0 40, 785, 047 29. 00

37, 538, 184

40, 785, 047

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1, 335, 622

19 00

20.00

21.00

22.00

23.00

23.50

24.00

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-1, 272

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1, 336, 894

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

0

0

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0

19 00

20.00

21.00

22.00

23.00

23. 50

Health Promotion Activities

Home Delivered Meals Program

Day Care Program

Homemaker Service

Tel emedi ci ne

All Others (specify)

24.00 Total (sum of lines 1-23)

	5' ' 1 0 1		MA 10D 1100	NO. TAI			6.5. 046	0550 40
	<u>Financial Systems</u> LLOCATION - HHA GENERAL SERVICE	COST	MAJOR HOS	Provider C	CN: 15-0097	Period:	u of Form CMS Worksheet H-1	
C031 F	LECCATION - THIA GENERAL SERVICE	. 0031		HHA CCN:	15-7418	From 01/01/2016 To 12/31/2016	Part I Date/Time Pre	pared:
						Home Health	5/25/2017 11: PPS	27 am
			0 11 1 0 1			Agency I		
			Capital Rel	ated Costs				
		Net Expenses	BI dgs &	Movabl e	PI ant	Transportati on		1
		for Cost	Fixtures	Equi pment	Operation &		(col s. 0-4)	
		Allocation (from Wkst. H,			Mai ntenance			
		col . 10)						
	CENERAL CERVICE COCT CENTERS	0	1.00	2. 00	3. 00	4. 00	4A. 00	
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0		I		0	1.00
00	Fi xtures		Ĭ					1 55
2.00	Capital Related - Movable	0		0			0	2. 00
3.00	Equipment Plant Operation & Maintenance	0	0	0		0	0	3.00
4. 00	Transportation	O	O	0		0 0	_	4. 00
5.00	Administrative and General	375, 342	0	0		0 0	375, 342	5.00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	431, 986	0	0	I	0 0	431, 986	6.00
7. 00	Physical Therapy	336, 255	0	0	l .	0 0	336, 255	
8.00	Occupational Therapy	91, 629	0	0		0 0	91, 629	1
9.00	Speech Pathology Medical Social Services	1, 856	0	0		0 0	1, 856	
10. 00 11. 00	Home Health Aide	3, 228 58, 955	0	0		0 0	3, 228 58, 955	
12. 00	Supplies (see instructions)	36, 371	0	0		0 0	36, 371	1
13. 00	Drugs	0	0	0		0	0	
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	0	14. 00
15. 00	Home Dialysis Aide Services	O	0	0		0 0	0	15. 00
16. 00	Respiratory Therapy	0	0	0	l .	0 0	0	1
17. 00	Private Duty Nursing	0	0	0	•	0 0	0	1
18. 00 19. 00	Clinic Health Promotion Activities		0	0	•	0 0	0	
20. 00	Day Care Program	l o	ő	0	•	0 0	0	1
21. 00	Home Delivered Meals Program	0	0	0		0 0	0	
22. 00 23. 00	Homemaker Service All Others (specify)	0	0	0	1	0 0	0	
23. 50	Telemedicine		0	0		0 0	0	1
24. 00	4	1, 335, 622	0	0	l .	0 0	1, 335, 622	
		Administrative						
		& General 5.00	4A + 5) 6.00					1
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &							1.00
2.00	Fixtures Capital Related - Movable							2. 00
	Equi pment							
3.00	Plant Operation & Maintenance							3.00
4. 00 5. 00	Transportation Administrative and General	375, 342						4. 00 5. 00
2.00	HHA REIMBURSABLE SERVICES	3,3,312						1
6.00	Skilled Nursing Care	168, 849	600, 835					6.00
7. 00 8. 00	Physical Therapy Occupational Therapy	131, 431 35, 815	467, 686 127, 444					7. 00 8. 00
9. 00	Speech Pathology	725	2, 581					9. 00
10.00	Medical Social Services	1, 262	4, 490					10. 00
11. 00 12. 00	Home Heal th Aide	23, 044 14, 216	81, 999 50, 587					11. 00 12. 00
13. 00	Supplies (see instructions) Drugs	14, 210	0, 567					13. 00
14. 00	DME	0	0					14. 00
15 00	HHA NONREI MBURSABLE SERVI CES							15.00
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy	0	0					15. 00 16. 00
17. 00	Private Duty Nursing	0	Ö					17. 00
18.00		0	0					18.00
19. 00 20. 00	Health Promotion Activities Day Care Program	0	0					19. 00 20. 00
21. 00	Home Delivered Meals Program		0					21.00
22. 00	Homemaker Service	0	О					22. 00
23. 00 23. 50	All Others (specify) Telemedicine	0	0					23. 00 23. 50
	Total (sum of lines 1-23)		1, 335, 622					24. 00
. ==		. '						

∐oal +h	Financial Systems		MAJOR HO	NT IDS		In lic	eu of Form CMS-2	2552 10
	ALLOCATION - HHA STATISTICAL BAS	SIS	WASOK TIC		CN: 15-0097	Peri od:	Worksheet H-1	
				HHA CCN:	15-7418	From 01/01/2016 To 12/31/2016		pared: 27 am
						Home Health	PPS	
		Canital Bal	ated Costs			Agency I		
		Capital Rei	ateu costs					
		BI dgs &	Movabl e	PI ant		onReconciliation		
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Maintenance (SQUARE FEET)			(ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS							
1. 00	Capital Related - Bldg. & Fixtures	0				0		1. 00
2.00	Capital Related - Movable		0			0		2. 00
3. 00	Equipment Plant Operation & Maintenance	0	0			0		3.00
4. 00	Transportation (see	Ö	Ö	d		0		4. 00
	instructions)							
5.00	Administrative and General	0	0			0 -375, 342	960, 280	5. 00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	T 0	0		7	0 0	431, 986	6.00
7. 00	Physical Therapy	0	0		1	0 0	336, 255	1
8.00	Occupational Therapy	0	0	C		0 0	91, 629	8. 00
9.00	Speech Pathology	0	0	C		0 0	1, 856	
10. 00	Medical Social Services	0	0	C		0 0	3, 228	1
11. 00	Home Heal th Aide	0	0			0 0	58, 955	1
12.00	Supplies (see instructions)	0	0			0 0	36, 371	1
13. 00 14. 00	Drugs DME		0			0 0	1	1
14.00	HHA NONREI MBURSABLE SERVI CES				4	0 0		14.00
15. 00	Home Dialysis Aide Services	0	0	C		0 0	0	15. 00
16.00	Respiratory Therapy	0	0	l c		0 0	0	16. 00
17.00	Private Duty Nursing	0	0	C		0 0	0	17. 00
18.00	Clinic	0	0	C		0 0	0	18. 00
19. 00	Health Promotion Activities	0	0	(0	0	19. 00
20. 00	Day Care Program	0	0	C		0 0	0	20. 00
	Home Delivered Meals Program	0	0			0 0	0	21. 00
22. 00	Homemaker Service	0	0]	0	0	22. 00
23. 00 23. 50	All Others (specify) Telemedicine					0		23. 00 23. 50
23. 50	Total (sum of lines 1-23)				(0 -375, 342	960, 280	1
25. 00	Cost To Be Allocated (per				á	0 -373,342	375, 342	
25.00	cost to be Arrocated (per	1	I	1	1	<u> </u>] 3,3,342	1 20.00

0.000000

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0. 390867 26. 00

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0. 000000

20.00 Day Care Program
21.00 Home Delivered Meals Program
22.00 Homemaker Service
23.00 All Others (specify)
23.50 Telemedicine
24.00 Total (sum of lines 1-23)
25.00 Cost To Be Allocated (per Worksheet H-1, Part I)
26.00 Unit Cost Multiplier

Worksheet H-2 Part I Date/Time Prepared: 5/25/2017 11:27 am Provider CCN: 15-0097 Peri od: From 01/01/2016 To 12/31/2016 HHA CCN: 15-7418 Home Health PPS

						Home Health Agency I	PPS	
	Cost Contar Description	HHA Trial	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE	COMMUNI CATI ONS		PURCHASI NG,	
	Cost Center Description	Balance (1)	BLUG & FIXI	BENEFITS DEPARTMENT	COMMUNICATIONS	PROCESSI NG	RECEIVING, AND STORES	
		0	1. 00	4. 00	5. 01	5. 02	5. 03	
1.00	Administrative and General	0	0	194, 565	0	77, 536	8, 526	1.00
2.00	Skilled Nursing Care	600, 835	0	0	0	0	0	2. 00
3.00	Physi cal Therapy	467, 686	0	0	0	0	0	3. 00
4.00	Occupational Therapy	127, 444	0	0	0	0	0	4. 00
5. 00	Speech Pathology	2, 581	0	0	0	0	0	5. 00
6. 00	Medical Social Services	4, 490	0	0	0	0	0	6. 00
7.00	Home Health Aide	81, 999	0	0	0	0	0	7. 00
8.00	Supplies (see instructions)	50, 587	0	0	0	0	0	8. 00
9.00	Drugs DME	0	0	0	0	0	0	9.00
10. 00 11. 00	Home Dialysis Aide Services	0	0	0	0	0	0	10. 00 11. 00
12. 00	Respiratory Therapy		0	0	0	0	0	12. 00
13. 00	Private Duty Nursing			0		0	0	13. 00
14. 00	Clinic	0	l ol	0		0	Ö	14. 00
15. 00	Health Promotion Activities	l o	l ol	0	o o	0	Ö	15. 00
16. 00	Day Care Program	0	o	0	0	0	o	16.00
17.00	Home Delivered Meals Program	0	o	0	0	0	O	17.00
18. 00	Homemaker Service	0	0	0	0	0	0	18.00
19. 00	All Others (specify)	0	0	0	0	0	0	19. 00
19. 50	Tel emedi ci ne	0	0	0	0	0	0	19. 50
20. 00	Total (sum of lines 1-19) (2)	1, 335, 622	0	194, 565	0	77, 536	8, 526	20. 00
21. 00	Unit Cost Multiplier: column							21. 00
	26, line 1 divided by the sum of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	ADMITTI NG	CASHI ERI NG/ACC	Subtotal	OTHER	OPERATION OF	LAUNDRY &	
		ADMI TTI NG	OUNTS	Subtotal	ADMI NI STRATI VE		LAUNDRY & LINEN SERVICE	
			OUNTS RECEI VABLE		ADMINISTRATIVE AND GENERAL	PLANT	LINEN SERVICE	
1.00	Cost Center Description	5. 04	OUNTS RECEI VABLE 5. 05	5A. 05	ADMINISTRATIVE AND GENERAL 5.06	PLANT 7. 00	LINEN SERVICE 8.00	1 00
1.00	Cost Center Description Administrative and General		OUNTS RECEI VABLE	5A. 05 305, 828	ADMI NI STRATI VE AND GENERAL 5. 06 39, 708	PLANT 7. 00	LINEN SERVICE 8.00	1.00
2.00	Cost Center Description Administrative and General Skilled Nursing Care	5. 04	OUNTS RECEI VABLE 5. 05 12, 461	5A. 05 305, 828 600, 835	ADMI NI STRATI VE AND GENERAL 5. 06 39, 708 78, 010	PLANT 7. 00	8.00 0	2. 00
	Cost Center Description Administrative and General	5. 04	OUNTS RECEI VABLE 5. 05 12, 461 0	5A. 05 305, 828	ADMI NI STRATI VE AND GENERAL 5. 06 39, 708 78, 010 60, 723	PLANT 7. 00	LINEN SERVICE 8.00	
2. 00 3. 00	Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy	5. 04	0UNTS RECEI VABLE 5. 05 12, 461 0	5A. 05 305, 828 600, 835 467, 686	ADMI NI STRATI VE AND GENERAL 5. 06 39, 708 78, 010 60, 723 16, 547	PLANT 7. 00	8. 00 0 0 0	2. 00 3. 00
2. 00 3. 00 4. 00	Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	5. 04	OUNTS RECEI VABLE 5. 05 12, 461 0 0	5A. 05 305, 828 600, 835 467, 686 127, 444	ADMI NI STRATI VE AND GENERAL 5. 06 39, 708 78, 010 60, 723 16, 547 335	7. 00 0 0 0	8.00 0 0 0	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	5. 04	OUNTS RECEI VABLE 5. 05 12, 461 0 0 0 0	5A. 05 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999	ADMI NI STRATI VE AND GENERAL 5. 06 39, 708 78, 010 60, 723 16, 547 335 583 10, 647	7. 00 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	5. 04	OUNTS RECEI VABLE 5. 05 12, 461 0 0 0 0	5A. 05 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490	ADMI NI STRATI VE AND GENERAL 5. 06 39, 708 78, 010 60, 723 16, 547 335 583 10, 647	7. 00 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	5. 04	OUNTS RECEI VABLE 5. 05 12, 461 0 0 0 0 0 0 0	5A. 05 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999	ADMI NI STRATI VE AND GENERAL 5. 06 39, 708 78, 010 60, 723 16, 547 335 583 10, 647	7. 00 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	5. 04	OUNTS RECEI VABLE 5. 05 12, 461 0 0 0 0	5A. 05 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999	ADMI NI STRATI VE AND GENERAL 5. 06 39, 708 78, 010 60, 723 16, 547 335 583 10, 647	7. 00 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	5. 04	OUNTS RECEI VABLE 5. 05 12, 461 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 05 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999	ADMI NI STRATI VE AND GENERAL 5. 06 39, 708 78, 010 60, 723 16, 547 335 583 10, 647	7. 00 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	5. 04	OUNTS RECEI VABLE 5. 05 12, 461 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 05 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999	ADMI NI STRATI VE AND GENERAL 5. 06 39, 708 78, 010 60, 723 16, 547 335 583 10, 647	7. 00 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	5. 04	OUNTS RECEI VABLE 5. 05 12, 461 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 05 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999	ADMI NI STRATI VE AND GENERAL 5. 06 39, 708 78, 010 60, 723 16, 547 335 583 10, 647	7. 00 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	5. 04	OUNTS RECEI VABLE 5. 05 12, 461 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 05 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999	ADMI NI STRATI VE AND GENERAL 5. 06 39, 708 78, 010 60, 723 16, 547 335 583 10, 647	7. 00 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	5. 04	OUNTS RECEI VABLE 5. 05 12, 461 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 05 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999	ADMI NI STRATI VE AND GENERAL 5. 06 39, 708 78, 010 60, 723 16, 547 335 583 10, 647	7. 00 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	5. 04	OUNTS RECEI VABLE 5. 05 12, 461 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 05 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999	ADMI NI STRATI VE AND GENERAL 5. 06 39, 708 78, 010 60, 723 16, 547 335 583 10, 647	7. 00 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	5. 04	OUNTS RECEI VABLE 5. 05 12, 461 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 05 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999	ADMI NI STRATI VE AND GENERAL 5. 06 39, 708 78, 010 60, 723 16, 547 335 583 10, 647	7. 00 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	5. 04	OUNTS RECEI VABLE 5. 05 12, 461 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 05 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999	ADMI NI STRATI VE AND GENERAL 5. 06 39, 708 78, 010 60, 723 16, 547 335 583 10, 647	7. 00 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	5. 04 12, 740 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	OUNTS RECEI VABLE 5. 05 12, 461 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 05 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999	ADMI NI STRATI VE AND GENERAL 5. 06 39, 708 78, 010 60, 723 16, 547 335 583 10, 647	7. 00 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	5. 04	OUNTS RECEI VABLE 5. 05 12, 461 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 05 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999 50, 587 0 0 0 0 0 0 0 1, 641, 450	ADMI NI STRATI VE AND GENERAL 5. 06 39, 708 78, 010 60, 723 16, 547 335 583 10, 647 6, 568 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7. 00 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 50 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	5. 04 12, 740 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	OUNTS RECEI VABLE 5. 05 12, 461 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 05 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999 50, 587 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI VE AND GENERAL 5. 06 39, 708 78, 010 60, 723 16, 547 335 583 10, 647 6, 568 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7. 00 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	5. 04 12, 740 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	OUNTS RECEI VABLE 5. 05 12, 461 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 05 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999 50, 587 0 0 0 0 0 0 0 1, 641, 450	ADMI NI STRATI VE AND GENERAL 5. 06 39, 708 78, 010 60, 723 16, 547 335 583 10, 647 6, 568 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7. 00 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 50 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	5. 04 12, 740 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	OUNTS RECEI VABLE 5. 05 12, 461 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 05 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999 50, 587 0 0 0 0 0 0 0 1, 641, 450	ADMI NI STRATI VE AND GENERAL 5. 06 39, 708 78, 010 60, 723 16, 547 335 583 10, 647 6, 568 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7. 00 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 50 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	5. 04 12, 740 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	OUNTS RECEI VABLE 5. 05 12, 461 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 05 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999 50, 587 0 0 0 0 0 0 0 1, 641, 450	ADMI NI STRATI VE AND GENERAL 5. 06 39, 708 78, 010 60, 723 16, 547 335 583 10, 647 6, 568 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7. 00 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 50 20. 00

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCA	ATTON OF GENERAL SERVICE COSTS I	O HHA COST CENT	IEKS	HHA CCN:	1	From 01/01/2016 To 12/31/2016		pared: 27 am
						Home Health	PPS	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI OI	Agency I CENTRAL SERVI CES & SUPPLY	PHARMACY	
		9. 00	10.00	11. 00	13. 00	14. 00	15. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 50 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
1.00		16. 00	24. 00	25. 00	26.00	27. 00	28. 00	1 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 50 20. 00 21. 00	Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	14, 405 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	407, 483 678, 845 528, 409 143, 991 2, 916 5, 073 92, 646 57, 155 0 0 0 0 0 0 0 0 0 0 0		0 407, 48: 0 678, 84: 0 528, 40: 0 143, 99: 0 2, 91: 0 5, 07: 0 92, 64: 0 57, 15: 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5 183, 307 9 142, 686 1 38, 882 787 3 1, 370 6 25, 017 5 15, 434 0	862, 152 671, 095 182, 873 3, 703 6, 443 117, 663 72, 589 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

BASIS HHA CCN: 15-7418 Home Health PPS

						Home Health Agency I	PPS	
		CAPI TAL				Agency 1		
		RELATED COSTS						
	Cost Center Description	BLDG & FIXT	EMPLOYEE	COMMUNI CATI ONS	DATA	PURCHASI NG,	ADMITTING	
		(SQUARE FEET)	BENEFITS		PROCESSI NG	RECEIVING, AND		
			DEPARTMENT	(TELEPHONES)	(HARDWARE)	STORES	CHARGES)	
			(GROSS			(PURCHASI NG)		
		1.00	SALARI ES) 4. 00	5. 01	5. 02	5. 03	5. 04	
1.00	Administrative and General	1.00	804, 878		12		2, 250, 052	1. 00
2. 00	Skilled Nursing Care	0	001,070	1	0	I -	0	2. 00
3.00	Physi cal Therapy	0	0	o	0	Ō	l	3. 00
4.00	Occupational Therapy	0	0	o	0	0	o	4. 00
5.00	Speech Pathology	0	0	o	0	0	o	5.00
6.00	Medical Social Services	0	0	O	0	0	o	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7. 00
8.00	Supplies (see instructions)	0	0		0	0	0	8.00
9.00	Drugs	0	0	-	0	0	0	9. 00
10.00	DME	0	0		0	_	0	10. 00
11.00	Home Dialysis Aide Services	0	0		0	_	0	11.00
12.00	Respiratory Therapy	0	0		0	_	0	12.00
13. 00 14. 00	Private Duty Nursing	0		_	0	0	0	13. 00 14. 00
15. 00	Health Promotion Activities	0		0	0	0	0	15. 00
16. 00	Day Care Program	0		0	0	0		16. 00
17. 00	Home Delivered Meals Program	0		0	0	0	Ö	17. 00
18. 00	Homemaker Service	0		Ö	0	0	l ől	18. 00
19. 00	All Others (specify)	0	0	o	0	Ö	o	19. 00
19. 50	Tel emedi ci ne	0	0	o	0	0	o	19. 50
20.00	Total (sum of lines 1-19)	0	804, 878	o	12	42, 153	2, 250, 052	20.00
21.00	Total cost to be allocated	0	194, 565	0	77, 536	8, 526	12, 740	21.00
22. 00	Unit cost multiplier	0. 000000	0. 241732		6, 461. 333333		0. 005662	22. 00
22. 00	Unit cost multiplier Cost Center Description	CASHI ERI NG/ACC		OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	22. 00
22. 00		CASHI ERI NG/ACC OUNTS		OTHER ADMI NI STRATI VE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG (SQUARE	22. 00
22. 00		CASHI ERI NG/ACC OUNTS RECEI VABLE		OTHER ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT (SQUARE	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG	22. 00
22. 00		CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS		OTHER ADMI NI STRATI VE AND GENERAL (ACCUM.	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG (SQUARE	22. 00
22. 00		CASHI ERI NG/ACC OUNTS RECEI VABLE		OTHER ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT (SQUARE	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (SQUARE	22. 00
1.00		CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST) 5.06	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00	HOUSEKEEPI NG (SQUARE FEET)	1. 00
	Cost Center Description	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	Reconciliation 5A. 06	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5.06 305,828	OPERATION OF PLANT (SQUARE FEET) 7.00	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00	HOUSEKEEPI NG (SQUARE FEET) 9.00	
1. 00 2. 00 3. 00	Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	Reconciliation 5A. 06	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 305, 828 600, 835 467, 686	OPERATION OF PLANT (SQUARE FEET) 7.00	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8. 00 0 0	HOUSEKEEPI NG (SQUARE FEET) 9.00 0 0	1. 00 2. 00 3. 00
1. 00 2. 00 3. 00 4. 00	Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	SA. 06	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 305, 828 600, 835 467, 686 127, 444	OPERATION OF PLANT (SQUARE FEET) 7.00	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0	HOUSEKEEPI NG (SQUARE FEET) 9.00 0 0 0	1. 00 2. 00 3. 00 4. 00
1. 00 2. 00 3. 00 4. 00 5. 00	Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	SA. 06	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 305, 828 600, 835 467, 686 127, 444 2, 581	OPERATION OF PLANT (SQUARE FEET) 7.00	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0	9. 00 9. 00 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	SA. 06	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0	POUSEKEEPI NG (SOUARE FEET) 9.00 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	SA. 06	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0	9.00 9.00 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	SA. 06	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999 50, 587	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 9. 00 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	SA. 06	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999 50, 587	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 9.00 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	SA. 06	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999 50, 587 0	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 9. 00 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	SA. 06	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999 50, 587 0 0	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 9. 00 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	SA. 06	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999 50, 587 0 0 0	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 9. 00 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	5A. 06	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999 50, 587 0 0 0	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 9. 00 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	5A. 06	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999 50, 587 0 0 0	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 9.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	5A. 06	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999 50, 587 0 0 0 0 0	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 9.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 11. 00 12. 00 13. 00 14. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	5A. 06	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999 50, 587 0 0 0 0 0 0 0	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 9. 00 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	5A. 06	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999 50, 587 0 0 0 0 0 0 0 0 0 0	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 9.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05	5A. 06	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5.06 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999 50, 587 0 0 0 0 0 0 0 0 0 0 0	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 9. 00 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05 2, 250, 052 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 06	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5.06 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999 50, 587 0 0 0 0 0 0 0 0 0 0 0 0 0	7.00 7.00 00 00 00 00 00 00 00 00 00 00 00 00	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 9. 00 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19)	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05 2, 250, 052 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 06	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5. 06 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999 50, 587 0 0 0 0 0 0 0 0 1, 641, 450	7.00 7.00 00 00 00 00 00 00 00 00 00 00 00 00	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 9. 00 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHARGES) 5. 05 2, 250, 052 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 06 5A. 06 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5.06 305, 828 600, 835 467, 686 127, 444 2, 581 4, 490 81, 999 50, 587 0 0 0 0 0 0 0 0 0 0 0 0 0	7.00 7.00 7.00 00 00 00 00 00 00 00 00 00 00 00 00	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 9. 00 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 20. 00 21. 00

Peri od: From 01/01/2016 To 12/31/2016 BASIS HHA CCN: 15-7418

						Home Health	PPS	
						Agency I		
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(PATI ENT	(MANHOURS)	ADMI NI STRATI ON		(100% DRUGS TO	RECORDS &	
		DAYS)			SUPPLY	PATI ENTS)	LI BRARY	
				(MANHOURS)	(100%		(GROSS	
					SUPPLI ES)		CHARGES)	
		10. 00	11. 00	13. 00	14. 00	15. 00	16. 00	
1.00	Administrative and General	0	C	26, 327	(이	2, 250, 052	1. 00
2.00	Skilled Nursing Care	0	C	0		0	0	2. 00
3.00	Physical Therapy	0	C	0	(0	0	3. 00
4.00	Occupational Therapy	0	C	0	(0	0	4. 00
5.00	Speech Pathology	0	C	0	(0	0	5. 00
6.00	Medical Social Services	0	C	0	(0	0	6. 00
7.00	Home Health Aide	0	C	0	(0	0	7. 00
8.00	Supplies (see instructions)	0	C	0	(0	0	8. 00
9.00	Drugs	0	C	0	(0	0	9. 00
10.00	DME	0	C	0	(0	0	10. 00
11. 00	Home Dialysis Aide Services	0	C	0	(0	0	11. 00
12.00	Respiratory Therapy	0	C	0		0	0	12. 00
13.00	Private Duty Nursing	0	C	0	(0	0	13. 00
14.00	Clinic	0	C	0	(0	0	14. 00
15. 00	Health Promotion Activities	0	C	0	(0	0	15. 00
16. 00	Day Care Program	0	C	0		0	0	16. 00
17. 00	Home Delivered Meals Program	0	C	0		0	0	17. 00
18. 00	Homemaker Service	0	C	0		0	0	18. 00
19.00	All Others (specify)	0	C	0	(0	0	19. 00
19. 50	Tel emedi ci ne	0	C	0	(0	0	19. 50
20.00	Total (sum of lines 1-19)	0	C	26, 327	(0	2, 250, 052	20. 00
21. 00	Total cost to be allocated	0	C	47, 542		0	14, 405	21. 00
22. 00	Unit cost multiplier	0. 000000	0. 000000	1. 805827	0. 000000	0. 000000	0. 006402	22. 00

	Financial Systems FIONMENT OF PATIENT SERVICE COST	-c	MAJOR HO		CN: 15-0097	Peri od:	u of Form CMS-2 Worksheet H-3	
APPURI	HOMMENT OF PATTENT SERVICE COST	3		HHA CCN:		From 01/01/2016 To 12/31/2016	Part I	pared:
				Ti tl e	e XVIII	Home Health Agency I	PPS	27 aiii
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.	1	Per Visit	
		col. 28, line	H-2, Part I)	Costs (from	+ 2)		(col. 3 ÷ col.	
		0	1.00	Part II) 2.00	3.00	4.00	4) 5. 00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation	1	1		1			
1.00	Skilled Nursing Care	2.00			862, 15			
2.00	Physical Therapy	3.00		0				
3.00	Occupational Therapy	4.00		0			203. 87	
4. 00 5. 00	Speech Pathology Medical Social Services	5. 00 6. 00		U	3, 70 6, 44		84. 16 107. 38	
6. 00	Home Heal th Aide	7. 00			117, 66			
7. 00	Total (sum of lines 1-6)	7.00	1, 843, 929	O			00.04	7. 00
					Program Visit			
					Pa	art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject t			
					Deducti bl es			
		0	1.00	2. 00	Coi nsurance 3.00	4. 00	5. 00	
	Limitation Cost Computation	0	1.00	2.00	3.00	4.00	5.00	
8. 00	Skilled Nursing Care		26900	0	3, 74	13		8.00
9. 00	Physi cal Therapy		26900	0			•	9. 00
10. 00	Occupational Therapy		26900	0	62	24		10.00
11. 00	Speech Pathology		26900	0) 2	24		11.00
12. 00	Medical Social Services		26900	0	1	33		12. 00
13. 00	Home Heal th Ai de		26900	0				13. 00
14. 00		- "		0			D () 0	14. 00
	Cost Center Description		Facility Costs	Shared	Total HHA		Ratio (col. 3	
		Part I, col. 28, line	(from Wkst. H-2, Part I)	Ancillary Costs (from	Costs (cols. + 2)	1 (from HHA Records)	÷ col. 4)	
		20, 11116	11-2, Tart 1)	Part II)	T 2)	Records)		
		0	1.00	2.00	3. 00	4. 00	5. 00	
	Supplies and Drugs Cost Computa							
15. 00	Cost of Medical Supplies	8. 00		0				
16. 00	Cost of Drugs	9. 00		0	-	0 0	0. 000000	16. 00
			Program Visits		Cost of Services			
			Par	† R	J Services	Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	
	5651 Control 25551 Pt. 611	''	Deductibles &			Deductibles &		
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6. 00	7.00	8. 00	9. 00	10.00	11. 00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	IE PROGRAM LIN	IITATION COST, OF	8	
	BENEFICIARY COST LIMITATION							+
1. 00	Cost Per Visit Computation Skilled Nursing Care	T 0	3, 743			0 579, 042		1.00
2. 00	Physical Therapy		1			0 466, 337		2.00
3. 00	Occupational Therapy				1	0 127, 215		3.00
4. 00	Speech Pathology	Ö	1			0 2,020		4. 00
5.00	Medical Social Services	0	33			0 3, 544		5. 00
6. 00	Home Health Aide	0				0 105, 653		6. 00
7. 00	Total (sum of lines 1-6)	0	8, 051			0 1, 283, 811		7. 00
	Cost Center Description	(00	7.00	0.00	0.00	10.00	11 00	
	Limitation Cost Computation	6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
8. 00	Skilled Nursing Care							8.00
9. 00	Physical Therapy							9.00
10. 00	Occupational Therapy							10.00
11. 00	Speech Pathology				1			11.00
11.00		1	1					12.00
12. 00	Medical Social Services							
	Medical Social Services Home Health Aide							13.00

Heal th	Financial Systems		MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF PATIENT SERVICE COST	-s		Provider CC HHA CCN:	CN: 15-0097 15-7418	Peri od: From 01/01/2016 To 12/31/2016		pared:
				Title	XVIII	Home Health Agency I	PPS	27 aiii
		Prog	ram Covered Cha	irges	Cost of Services	Agency I		
	Cost Center Description	Part A	Par Not Subject to Deductibles & Coinsurance	Subject to	Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
	Supplies and Drugs Cost Computa							
	Cost of Medical Supplies	0		- 1		0 0		
16.00	Cost of Drugs Cost Center Description	Total Program	0	0		0	0	16.00
	Cost Center Description	Cost (sum of cols. 9-10)						
		12. 00	-					1
	PART I - COMPUTATION OF LESSER		PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	}	
	BENEFICIARY COST LIMITATION]
	Cost Per Visit Computation	1	1					
1.00	Skilled Nursing Care	579, 042						1.00
2.00	Physical Therapy	466, 337						2.00
3.00	Occupational Therapy	127, 215						3.00
4. 00 5. 00	Speech Pathology Medical Social Services	2, 020						4. 00 5. 00
6.00	Home Health Aide	3, 544						6.00
7.00	Total (sum of lines 1-6)	105, 653 1, 283, 811						7.00
7.00	Cost Center Description	1, 203, 011						7.00
	cost center bescription	12. 00						1
	Limitation Cost Computation	12.00						
8.00	Skilled Nursing Care							8.00
9. 00	Physical Therapy							9. 00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
40.00	Home Health Aide							13.00
13.00								

Heal th	Financial Systems		MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF PATIENT SERVICE COST	S		Provi der C		Peri od:	Worksheet H-3	
				HHA CCN:	15-7418	From 01/01/2016 To 12/31/2016		narod:
				TITIA CCN.	15-7416	10 12/31/2010	5/25/2017 11:	
				Ti tl e	e XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge		HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1. 00	2. 00	3.00	4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIO	ES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00	Physical Therapy	66. 00	0. 397272	0		0 col. 2, line 2	. 00	1. 00
2.00	Occupational Therapy							2. 00
3.00	Speech Pathology							3. 00
4.00	Cost of Medical Supplies	71.00	0. 235949	0)	0 col. 2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73.00	0. 344620	0)	0 col. 2, line 1	6. 00	5. 00

th Financial Systems MAJOR HOSPI CULATION OF HHA REIMBURSEMENT SETTLEMENT	TAL Provider CC	°N: 15_0007	In Li Peri od:	eu of Form CMS-3 Worksheet H-4	
SULATION OF HHA REIMBURSEMENT SETTLEMENT	HHA CCN:	15-7418	From 01/01/201 To 12/31/201	6 Part I-II	par
	Title	XVIII	Home Health Agency I	PPS	
			Pa	rt B	
		Part A	Not Subject t Deductibles & Coinsurance	O Subject to Deductibles & Coinsurance	
		1.00	2. 00	3. 00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO	MARY CHARGES	S			
Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)	T		0	0 0	1
7 Total charges					
Customary Charges	1			-1	
Amount actually collected from patients liable for payment for	servi ces		0	0 0] 3
on a charge basis (from your records)	novmont		0	0	
Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in a with 42 CFR §413.13(b)				0	
Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 00000	0. 000000	[
Total customary charges (see instructions)	, ,		0	0	
Excess of total customary charges over total reasonable cost (only if line 6 exceeds line 1)	complete		0	0 0	'
Excess of reasonable cost over customary charges (complete onl 1 exceeds line 6)	yifline		0	0	
Primary payer amounts				0 0	1
			Part A Services	Part B Services	
			1. 00	2. 00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
Total reasonable cost (see instructions)				0 0	
00 Total PPS Reimbursement - Full Episodes without Outliers 00 Total PPS Reimbursement - Full Episodes with Outliers				0 989, 530 0 106, 785	
00 Total PPS Reimbursement - LUPA Episodes				0 9, 567	
00 Total PPS Reimbursement - PEP Episodes				0 7, 105	
OO Total PPS Outlier Reimbursement - Full Episodes with Outliers				0 20, 911	
OO Total PPS Outlier Reimbursement - PEP Episodes				0 855	1
OO Total Other Payments				0 0	
DO DME Payments				0	
00 Oxygen Payments 00 Prosthetic and Orthotic Payments				0 0	
00 Part B deductibles billed to Medicare patients (exclude coinsu	irance)			0	1 -
OO Subtotal (sum of lines 10 thru 20 minus line 21)	ii dilee)			0 1, 134, 753	
00 Excess reasonable cost (from line 8)				0 0	1
OO Subtotal (line 22 minus line 23)				0 1, 134, 753	2
OO Coinsurance billed to program patients (from your records)				0	1 -
Net cost (line 24 minus line 25)				0 1, 134, 753	
00 Reimbursable bad debts (from your records) 00 Reimbursable bad debts for dual eligible beneficiaries (see in	etructione)				2 2
OD Total costs - current cost reporting period (line 26 plus line				0 1, 134, 753	
OO OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	, _,,			0 0	
Pioneer ACO demonstration payment adjustment (see instructions	s)			0	
OO Subtotal (see instructions)				0 1, 134, 753	3
,				0 22, 695	
Ol Sequestration adjustment (see instructions)			1	0 1, 112, 058	32
Ol Sequestration adjustment (see instructions) Ol Interim payments (see instructions)					
Sequestration adjustment (see instructions) Interim payments (see instructions) Tentative settlement (for contractor use only)	and 22)			0	33
Ol Sequestration adjustment (see instructions) Ol Interim payments (see instructions)		Pub 15-2			33

Health Financial Systems MAJOR HOMANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES Provider CCN: 15-0097 Peri od: From 01/01/2016 To 12/31/2016 Worksheet H-5 Date/Time Prepared: 5/25/2017 11:27 am HHA CCN: 15-7418

				Home Health Agency I	PPS	
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider 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	1, 112, 058 0	1. 00 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) Program to Provider					3. 00
3. 01				D	0	3. 01
3. 02					0	3. 02
3. 03 3. 04					0	3. 03 3. 04
3. 05						3. 05
0.00	Provider to Program			<u> </u>	<u> </u>	0.00
3.50			(D	0	3. 50
3. 51				D	0	3. 51
3. 52				0	0	3. 52
3.53					0	3. 53
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 54 3. 99
3. 77	3. 50-3. 98)		'		ا	3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		(1, 112, 058	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			_1	_	
5. 01					0	5. 01
5. 02 5. 03						5. 02 5. 03
3.03	Provider to Program		<u> </u>	21		5. 05
5.50	The state of the s		(o l	0	5. 50
5. 51				D	0	5. 51
5. 52				O	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		(D)	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)			Contractor	1, 112, 058 NPR Date	7. 00
		(1	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		J	1.00	2.00	8. 00
0.00	Induite of contractor			Ţ	ı	0.00

CALCIII	Financial Systems MA. ATION OF CAPITAL PAYMENT	JOR HOSPITAL Provider CCN: 15-0097	Period:	eu of Form CMS-2 Worksheet L	2552-10
CALCUI	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0097	From 01/01/2016 To 12/31/2016	Parts I-III Date/Time Pre	
		Title XVIII	Hospi tal	5/25/2017 11: PPS	27 alli
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				1
1 00	CAPITAL FEDERAL AMOUNT			(04.227	1
1. 00 1. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier			694, 327 0	1
2. 00	Capital DRG outlier payments			4, 915	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3.00	Total inpatient days divided by number of days in the	cost reporting period (see ins	tructions)	29. 44	
4.00	Number of interns & residents (see instructions)		,	0.00	4.00
5.00	Indirect medical education percentage (see instruction	ns)		0.00	5. 00
6. 00	Indirect medical education adjustment (multiply line 1.01) (see instructions)	5 by the sum of lines 1 and 1.0	1, columns 1 and	0	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare 30) (see instructions)		E, part A line	0.00	
8.00	Percentage of Medicaid patient days to total days (se	e instructions)		0.00	
9.00	Sum of lines 7 and 8	rusti enel		0. 00 0. 00	
10. 00 11. 00	Allowable disproportionate share percentage (see inst Disproportionate share adjustment (see instructions)	ructions)		0.00	
12. 00				699, 242	
12.00	prospective capital payments (see thisti detrons)			077,212	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				1
1.00	Program inpatient routine capital cost (see instructi	•		0	
2.00	Program inpatient ancillary capital cost (see instruc			0	
4. 00	Total inpatient program capital cost (line 1 plus lin Capital cost payment factor (see instructions)	e 2)		0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			
0.00	Trotal impatront program capital cost (ime o'x ime i)			0.00
				1. 00	
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS				1 00
1. 00 2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary cir	cumstances (see instructions)		0	
3. 00	Net program inpatient capital costs for extraordinary cri	` '			
4. 00	Applicable exception percentage (see instructions)	C 2)		0.00	
5. 00	Capital cost for comparison to payments (line 3 x lin	e 4)		0	
	Percentage adjustment for extraordinary circumstances	(see instructions)		0.00	6.00
6.00	Adjustment to capital minimum payment level for extra	ordinary circumstances (line 2)	x line 6)	0	7.00
6. 00 7. 00	That as the received the minimum payment rever not extra				8.00
7. 00 8. 00	Capital minimum payment level (line 5 plus line 7)	· ·		0	
7. 00 8. 00 9. 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12,	as applicable)		0	9. 00
7. 00 8. 00 9. 00 10. 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, Current year comparison of capital minimum payment le	as applicable) vel to capital payments (line 8	,	0	9. 00 10. 00
7. 00 8. 00 9. 00 10. 00 11. 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, Current year comparison of capital minimum payment le Carryover of accumulated capital minimum payment leve Worksheet L, Part III, line 14)	as applicable) vel to capital payments (line 8 I over capital payment (from pri	ior year	0 0	9. 00 10. 00 11. 00
7. 00 8. 00 9. 00 10. 00 11. 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, Current year comparison of capital minimum payment leve Carryover of accumulated capital minimum payment leve Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to ca	as applicable) vel to capital payments (line 8 I over capital payment (from pri pital payments (line 10 plus lin	ior year ne 11)	0 0 0	9. 00 10. 00 11. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, Current year comparison of capital minimum payment le Carryover of accumulated capital minimum payment leve Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to ca Current year exception payment (if line 12 is positiv	as applicable) vel to capital payments (line 8 I over capital payment (from pri pital payments (line 10 plus line, enter the amount on this line	ior year ne 11) e)	0 0 0	9. 00 10. 00 11. 00 12. 00 13. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, Current year comparison of capital minimum payment leve Carryover of accumulated capital minimum payment leve Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to ca Current year exception payment (if line 12 is positiv Carryover of accumulated capital minimum payment leve (if line 12 is negative, enter the amount on this lin	as applicable) vel to capital payments (line 8 I over capital payment (from pri pital payments (line 10 plus line e, enter the amount on this line I over capital payment for the	ior year ne 11) e)	0 0 0 0	9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, Current year comparison of capital minimum payment le Carryover of accumulated capital minimum payment leve Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to ca Current year exception payment (if line 12 is positiv Carryover of accumulated capital minimum payment leve (if line 12 is negative, enter the amount on this lin Current year allowable operating and capital payment	as applicable) vel to capital payments (line 8 I over capital payment (from pri pital payments (line 10 plus line e, enter the amount on this line I over capital payment for the e) (see instructions)	ior year ne 11) e)	0 0 0	9. 00 10. 00 11. 00 12. 00 13. 00 14. 00