This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0091	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/22/2017 9:23 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/22/2017 Time: 9:23 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HUNTINGTON MEMORIAL HOSPITAL (15-0091) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	33,702	39,946	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	33,702	39,946	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/19/2017 9:13 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2001 STULTS ROAD	PO Box:			1.00
2.00	City: HUNTINGTON	State: IN	Zip Code: 46750	County: HUNTINGTON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	HUNTINGTON MEMORIAL HOSPITAL	150091	99915	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	91	620	0	0	730	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/19/2017 9:13 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1	10/01/2016	27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/19/2017 9:13 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 5/19/2017 9:13 am

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

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

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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	58,808	0	125,137	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 5/19/2017 9:13 am

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15HO32	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: PARKVIEW HEALTH SYSTEM, INC.	Contractor's Name: WISCONSIN PHYSICIANS SERVICE	Contractor's Number: 08101	141.00
142.00	Street: 10501 CORPORATE DRIVE	PO Box: 5600		142.00
143.00	City: FORT WAYNE	State: IN	Zip Code: 46895-5600	143.00

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0091	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/19/2017 9:13 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II | Date/Time Prepared: 5/19/2017 9:13 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/23/2016	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/01/2017	Y	05/01/2017	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Y		Y		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 5/19/2017 9:13 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ERIC		NICKESON		41.00
42.00	Enter the employer/company name of the cost report preparer.	PARKVIEW HEALTH SYSTEM, INC.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(260) 373-8406		ERIC.NICKESON@PARKVIEW.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0091	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/19/2017 9:13 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR, REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 5/19/2017 9:13 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	36	13,176	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		36	13,176	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		36	13,176	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		36				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/19/2017 9:13 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,633	51	4,336			1.00
2.00	HMO and other (see instructions)	881	1,305				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,633	51	4,336			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		35	748			13.00
14.00	Total (see instructions)	1,633	86	5,084	0.00	215.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	215.00	27.00
28.00	Observation Bed Days		272	1,191			28.00
29.00	Ambulance Trips	1,519					29.00
30.00	Employee discount days (see instruction)			91			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	50	81			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 5/19/2017 9:13 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	527	516	1,606	1.00
2.00	HMO and other (see instructions)			287	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	527	516	1,606	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 5/19/2017 9:13 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	14,178,804	3,297,706	17,476,510	588,008.00	29.72	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		24,000	0	24,000	191.00	125.65	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		3,303,681	0	3,303,681	108,586.00	30.42	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,787,995	298,600	2,086,595	84,995.00	24.55	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		3,303,681	0	3,303,681	108,586.00	30.42	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		3,592,415	0	3,592,415			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		619,886	0	619,886			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		942,547	0	942,547			25.50
25.51	Related orgainzation wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	1,348,924	-1,348,924	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	1,986,892	3,321,364	5,308,256	152,626.00	34.78	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 5/19/2017 9:13 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	310,502	39,415	349,917	13,550.00	25.82	30.00
31.00	Laundry & Linen Service	8.00	0	29,633	29,633	2,257.00	13.13	31.00
32.00	Housekeeping	9.00	299,038	8,338	307,376	20,308.00	15.14	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	362,460	-290,961	71,499	6,106.00	11.71	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	213,772	213,772	16,075.00	13.30	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	186,433	23,673	210,106	5,207.00	40.35	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	543,828	0	543,828	10,378.00	52.40	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part III Date/Time Prepared: 5/19/2017 9:13 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		10,875,123	3,297,706	14,172,829	479,422.00	29.56	1.00
2.00	Excluded area salaries (see instructions)		1,787,995	298,600	2,086,595	84,995.00	24.55	2.00
3.00	Subtotal salaries (line 1 minus line 2)		9,087,128	2,999,106	12,086,234	394,427.00	30.64	3.00
4.00	Subtotal other wages & related costs (see inst.)		3,303,681	0	3,303,681	108,586.00	30.42	4.00
5.00	Subtotal wage-related costs (see inst.)		4,534,962	0	4,534,962	0.00	37.52	5.00
6.00	Total (sum of lines 3 thru 5)		16,925,771	2,999,106	19,924,877	503,013.00	39.61	6.00
7.00	Total overhead cost (see instructions)		5,038,077	1,996,310	7,034,387	226,507.00	31.06	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part IV Date/Time Prepared: 5/19/2017 9:13 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	227,148	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	563,220	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	52,645	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	2,279,685	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	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	22,303	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	60,154	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	16,488	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	917,644	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	37,426	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	32,902	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4,209,615	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part V Date/Time Prepared: 5/19/2017 9:13 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	4,209,615	1.00
2.00	Hospital	0	4,209,615	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 5/19/2017 9:13 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.213345	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,613,212	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,085,839	5.00
6.00	Medicaid charges	15,919,851	6.00
7.00	Medicaid cost (line 1 times line 6)	3,396,421	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	697,370	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	1,826	9.00
10.00	Stand-alone CHIP charges	6,159	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	1,314	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	2,550,014	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	18,832,202	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	4,017,756	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	1,467,742	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,165,112	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	1,521,374	985,507	2,506,881	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	324,578	210,253	534,831	21.00
22.00	Partial payment by patients approved for charity care	0	451	451	22.00
23.00	Cost of charity care (line 21 minus line 22)	324,578	209,802	534,380	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	5,743,885	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	57,916	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	5,685,969	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,213,073	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,747,453	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,912,565	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/19/2017 9:13 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,379,435	1,379,435	28,825	1,408,260	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		877,459	877,459	36,147	913,606	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,348,924	4,456,533	5,805,457	-1,348,924	4,456,533	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,986,892	12,326,755	14,313,647	-40,180	14,273,467	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	310,502	930,204	1,240,706	39,415	1,280,121	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	147,401	147,401	29,633	177,034	8.00
9.00	00900	HOUSEKEEPING	299,038	85,041	384,079	8,338	392,417	9.00
10.00	01000	DIETARY	362,460	385,035	747,495	-554,466	193,029	10.00
11.00	01100	CAFETERIA	0	6,072	6,072	412,539	418,611	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	186,433	6,932	193,365	23,673	217,038	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	543,828	747,679	1,291,507	0	1,291,507	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,043,465	340,672	3,384,137	-358,445	3,025,692	30.00
43.00	04300	NURSERY	0	0	0	144,276	144,276	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	840,472	477,045	1,317,517	107,838	1,425,355	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	600,726	600,726	52.00
53.00	05300	ANESTHESIOLOGY	0	550,901	550,901	0	550,901	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	844,145	545,180	1,389,325	103,316	1,492,641	54.00
60.00	06000	LABORATORY	0	2,117,798	2,117,798	-145	2,117,653	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	586,593	105,888	692,481	74,485	766,966	65.00
66.00	06600	PHYSICAL THERAPY	1,005,979	73,742	1,079,721	-186,354	893,367	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	236,793	236,793	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	75,827	75,827	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,562,754	1,562,754	-834,831	727,923	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	834,749	834,749	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,137,700	2,137,700	68,475	2,206,175	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	8,789	1,868	10,657	0	10,657	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,023,289	203,140	1,226,429	123,751	1,350,180	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,717,259	198,487	1,915,746	218,055	2,133,801	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		6,164	6,164	-6,164	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,108,068	29,669,885	43,777,953	-162,648	43,615,305	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	66,045	21,328	87,373	8,386	95,759	192.00
194.00	07950	OCC HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	-12,335	-12,335	12,335	0	194.02
194.03	07953	FOUNDATIO	29	80,001	80,030	0	80,030	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	4,662	426,488	431,150	0	431,150	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	0	141,927	141,927	194.07
194.08	07958	AUTISM CENTER	0	66,741	66,741	0	66,741	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
200.00		TOTAL (SUM OF LINES 118-199)	14,178,804	30,252,108	44,430,912	0	44,430,912	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 5/19/2017 9:13 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,201,490	206,770		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-206,011	707,595		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,634,385	1,822,148		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,761,169	11,512,298		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	-10,979	1,269,142		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	177,034		8.00
9.00	00900	HOUSEKEEPING	0	392,417		9.00
10.00	01000	DIETARY	-12,330	180,699		10.00
11.00	01100	CAFETERIA	-218,236	200,375		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	-11,567	205,471		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	-724,467	567,040		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-102,399	2,923,293		30.00
43.00	04300	NURSERY	0	144,276		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-540,414	884,941		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	600,726		52.00
53.00	05300	ANESTHESIOLOGY	0	550,901		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,492,641		54.00
60.00	06000	LABORATORY	0	2,117,653		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	-25,772	741,194		65.00
66.00	06600	PHYSICAL THERAPY	-3,065	890,302		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	236,793		67.00
68.00	06800	SPEECH PATHOLOGY	0	75,827		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	727,923		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	834,749		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,206,175		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	10,657		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-38,862	1,311,318		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-15,950	2,117,851		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-8,507,096	35,108,209		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	95,759		192.00
194.00	07950	OCC HEALTH	0	0		194.00
194.01	07951	PAIN CLINIC	0	0		194.01
194.02	07952	OCC HEALTH	0	0		194.02
194.03	07953	FOUNDATIO	0	80,030		194.03
194.04	07954	KIDS CAMPUS	0	0		194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	431,150		194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0		194.06
194.07	07957	MISC CATERING	0	141,927		194.07
194.08	07958	AUTISM CENTER	0	66,741		194.08
194.09	07959	HUNTINGTON BUA	0	0		194.09
200.00		TOTAL (SUM OF LINES 118-199)	-8,507,096	35,923,816		200.00

RECLASSIFICATIONS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/19/2017 9:13 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA AND CATERING				
1.00	CAFETERIA	11.00	213,772	198,767	1.00
2.00	MISC CATERING	194.07	72,159	69,768	2.00
	0		285,931	268,535	
	B - INTEREST				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,164	1.00
	TOTALS		0	6,164	
	F - INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	28,825	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	29,983	2.00
	0		0	58,808	
	G - LAUNDRY				
1.00	LAUNDRY & LINEN SERVICE	8.00	29,633	0	1.00
	0		29,633	0	
	H - HOME OFFICE SALARY				
1.00	ADMINISTRATIVE & GENERAL	5.00	3,303,681	0	1.00
	0		3,303,681	0	
	I - PTO				
1.00	ADMINISTRATIVE & GENERAL	5.00	18,628	0	1.00
2.00	OPERATION OF PLANT	7.00	39,415	0	2.00
3.00	HOUSEKEEPING	9.00	37,971	0	3.00
4.00	NURSING ADMINISTRATION	13.00	23,673	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	386,557	0	5.00
6.00	OPERATING ROOM	50.00	107,838	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	107,188	0	7.00
8.00	RESPIRATORY THERAPY	65.00	74,485	0	8.00
9.00	PHYSICAL THERAPY	66.00	127,738	0	9.00
10.00	DRUGS CHARGED TO PATIENTS	73.00	69,054	0	10.00
11.00	EMERGENCY	91.00	129,936	0	11.00
12.00	AMBULANCE SERVICES	95.00	218,055	0	12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	8,386	0	13.00
	0		1,348,924	0	
	J - SALARY				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	945	1.00
2.00	DIETARY	10.00	0	5,030	2.00
	0		0	5,975	
	K - OCC HEALTH				
1.00	OCC HEALTH	194.02	0	12,335	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	0		0	12,335	
	L - IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	834,749	1.00
	0		0	834,749	
	M - OB				
1.00	NURSERY	43.00	129,110	15,166	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	537,578	63,148	2.00
	0		666,688	78,314	
	O - THERAPY				
1.00	OCCUPATIONAL THERAPY	67.00	217,465	19,328	1.00
2.00	SPEECH PATHOLOGY	68.00	69,638	6,189	2.00
	0		287,103	25,517	
500.00	Grand Total: Increases		5,921,960	1,290,397	500.00

RECLASSIFICATIONS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/19/2017 9:13 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA AND CATERING						
1.00	DIETARY	10.00	285,931	268,535	0		1.00
2.00		0.00	0	0	0		2.00
	0		285,931	268,535			
	B - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	6,164	11		1.00
	TOTALS		0	6,164			
	F - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	58,808	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	58,808			
	G - LAUNDRY						
1.00	HOUSEKEEPING	9.00	29,633	0	0		1.00
	0		29,633	0			
	H - HOME OFFICE SALARY						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,303,681	0		1.00
	0		0	3,303,681			
	I - PTO						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,348,924	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
	0		1,348,924	0			
	J - SALARY						
1.00	ADMINISTRATIVE & GENERAL	5.00	945	0	0		1.00
2.00	DIETARY	10.00	5,030	0	0		2.00
	0		5,975	0			
	K - OCC HEALTH						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,872	0		1.00
2.00	LABORATORY	60.00	0	145	0		2.00
3.00	PHYSICAL THERAPY	66.00	0	1,472	0		3.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	579	0		5.00
6.00	EMERGENCY	91.00	0	6,185	0		6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	82	0		7.00
	0		0	12,335			
	L - IMPLANTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	834,749	0		1.00
	0		0	834,749			
	M - OB						
1.00	ADULTS & PEDIATRICS	30.00	666,688	78,314	0		1.00
2.00		0.00	0	0	0		2.00
	0		666,688	78,314			
	O - THERAPY						
1.00	PHYSICAL THERAPY	66.00	287,103	25,517	0		1.00
2.00		0.00	0	0	0		2.00
	0		287,103	25,517			
500.00	Grand Total: Decreases		2,624,254	4,588,103			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I | Date/Time Prepared: 5/19/2017 9:13 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	465,871	79,015	0	79,015	13,245	2.00
3.00	Buildings and Fixtures	1,927,095	389,629	0	389,629	0	3.00
4.00	Building Improvements	32,500	35,419	0	35,419	0	4.00
5.00	Fixed Equipment	1,250,412	130,055	0	130,055	0	5.00
6.00	Movable Equipment	10,802,524	1,831,283	0	1,831,283	494,114	6.00
7.00	HIT designated Assets	2,742,800	34,310	0	34,310	0	7.00
8.00	Subtotal (sum of lines 1-7)	17,221,202	2,499,711	0	2,499,711	507,359	8.00
9.00	Reconciling Items	2,586,017	-108,733	0	-108,733	0	9.00
10.00	Total (line 8 minus line 9)	14,635,185	2,608,444	0	2,608,444	507,359	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	531,641	128,649	2.00
3.00	Buildings and Fixtures	2,316,724	341,690	3.00
4.00	Building Improvements	67,919	0	4.00
5.00	Fixed Equipment	1,380,467	539,055	5.00
6.00	Movable Equipment	12,139,693	7,110,290	6.00
7.00	HIT designated Assets	2,777,110	0	7.00
8.00	Subtotal (sum of lines 1-7)	19,213,554	8,119,684	8.00
9.00	Reconciling Items	2,477,284	0	9.00
10.00	Total (line 8 minus line 9)	16,736,270	8,119,684	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part II | Date/Time Prepared: 5/19/2017 9:13 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	145,702	1,232,108	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	767,174	101,447	0	0	3,852	2.00
3.00	Total (sum of lines 1-2)	912,876	1,333,555	0	0	3,852	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	1,625	1,379,435	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,986	877,459	2.00
3.00	Total (sum of lines 1-2)	6,611	2,256,894	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 5/19/2017 9:13 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	4,296,752	0	4,296,752	0.264940	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	12,139,693	218,617	11,921,076	0.735060	0	2.00
3.00	Total (sum of lines 1-2)	16,436,445	218,617	16,217,828	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	176,320	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	567,327	101,447	2.00
3.00	Total (sum of lines 1-2)	0	0	0	743,647	101,447	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	28,825	0	1,625	206,770	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	29,983	3,852	4,986	707,595	2.00
3.00	Total (sum of lines 1-2)	0	58,808	3,852	6,611	914,365	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/19/2017 9:13 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-6,164	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,582	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-435	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-573,153			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-2,784,328			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	A	-38,086	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	A	-5,030	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	ADVERTISING	A	-2,000	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	TELEPHONE SERVICES	A	-297	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 5/19/2017 9:13 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	VENDING	A	-1,581	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.03	VENDING	A	-749	OPERATION OF PLANT	7.00	0	33.03
33.04	RENT	A	-964,968	CAP REL COSTS-BLDG & FIXT	1.00	10	33.04
33.05	RENT	A	-18,187	CAP REL COSTS-BLDG & FIXT	1.00	10	33.05
33.06	RENT	A	-244,153	CAP REL COSTS-BLDG & FIXT	1.00	10	33.06
33.07	PHARMACY EMPLOYEE PURCHASES	B	-679,447	PHARMACY	15.00	0	33.07
33.08	PHYSICIAN RECRUITMENT	A	-25,000	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	RENT	A	-4,800	CAP REL COSTS-BLDG & FIXT	1.00	10	33.09
33.10	SELF INSURANCE	A	-2,632,507	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	GUEST MEALS	A	-22,828	CAFETERIA	11.00	0	33.11
33.12	OTHER OPERATING REVENUE	A	-23,862	EMERGENCY	91.00	0	33.12
33.13	LOBBY DUES	A	-3,690	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	LIQUOR	A	-854	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	OTHER OPERATING REVENUE	B	-11,567	NURSING ADMINISTRATION	13.00	0	33.15
33.16	CONSULTING PT REVENUE	B	-165	PHYSICAL THERAPY	66.00	0	33.16
33.18	OTHER OPERATING REVENUE	B	-51,332	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	OTHER OPERATING REVENUE	B	-7,300	DIETARY	10.00	0	33.19
33.20	OTHER OPERATING REVENUE	B	-157,322	CAFETERIA	11.00	0	33.20
33.21	OTHER OPERATING REVENUE	B	-45,020	PHARMACY	15.00	0	33.21
33.24	OTHER OPERATING REVENUE	B	-23,033	RESPIRATORY THERAPY	65.00	0	33.24
33.25	OTHER OPERATING REVENUE	B	-2,900	PHYSICAL THERAPY	66.00	0	33.25
33.27	OTHER OPERATING REVENUE	B	-950	AMBULANCE SERVICES	95.00	0	33.27
33.29	TELEMETRY	A	26,543	ADULTS & PEDIATRICS	30.00	0	33.29
33.30	OTHER OPERATING REVENUE	B	-128,942	ADULTS & PEDIATRICS	30.00	0	33.30
33.31	OTHER OPERATING REVENUE	B	-9,795	OPERATION OF PLANT	7.00	0	33.31
34.00	DEPRECIATION	A	30,618	CAP REL COSTS-BLDG & FIXT	1.00	9	34.00
35.00	DEPRECIATION	A	-199,847	CAP REL COSTS-MVBLE EQUIP	2.00	9	35.00
37.00	PHYS ADMIN SALARIES	A	107,617	ADMINISTRATIVE & GENERAL	5.00	0	37.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,507,096				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 5/19/2017 9:13 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATIONS	8,304,806	6,981,000	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	PPG SUBSIDY	0	4,108,134	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			8,304,806	11,089,134	5.00

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0091	Period: From 01/01/2016 To 12/31/2016	Worksheet A-8-1 Date/Time Prepared: 5/19/2017 9:13 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	1,323,806	0		1.00
2.00	-4,108,134	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-2,784,328			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 5/19/2017 9:13 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	562,397	538,397	24,000	239,400	191	1.00
2.00	65.00	RESPIRATORY THERAPY	2,739	2,739	0	0	0	2.00
3.00	91.00	EMERGENCY	15,000	15,000	0	0	0	3.00
4.00	95.00	AMBULANCE SERVICES	15,000	15,000	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			595,136	571,136	24,000		191	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATING ROOM	21,983	1,099	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	95.00	AMBULANCE SERVICES	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			21,983	1,099	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	OPERATING ROOM	0	21,983	2,017	540,414		1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	2,739		2.00
3.00	91.00	EMERGENCY	0	0	0	15,000		3.00
4.00	95.00	AMBULANCE SERVICES	0	0	0	15,000		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	21,983	2,017	573,153		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/19/2017 9:13 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	206,770	206,770				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	707,595		707,595			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,822,148	234	0	1,822,382		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,512,298	13,618	10,647	553,526	12,090,089	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,269,142	54,384	24,332	36,488	1,384,346	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	177,034	1,115	0	3,090	181,239	8.00
9.00	00900	HOUSEKEEPING	392,417	908	0	32,052	425,377	9.00
10.00	01000	DIETARY	180,699	8,673	1,642	7,456	198,470	10.00
11.00	01100	CAFETERIA	200,375	1,968	0	22,291	224,634	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	205,471	0	0	21,909	227,380	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,378	0	0	3,378	14.00
15.00	01500	PHARMACY	567,040	2,048	60,742	56,708	686,538	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,131	0	0	1,131	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,923,293	44,609	85,899	288,149	3,341,950	30.00
43.00	04300	NURSERY	144,276	181	0	13,463	157,920	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	884,941	16,992	107,852	98,886	1,108,671	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	600,726	0	0	56,056	656,782	52.00
53.00	05300	ANESTHESIOLOGY	550,901	0	0	0	550,901	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,492,641	21,297	193,253	99,201	1,806,392	54.00
60.00	06000	LABORATORY	2,117,653	3,227	0	0	2,120,880	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	741,194	2,386	31,559	68,935	844,074	65.00
66.00	06600	PHYSICAL THERAPY	890,302	14,758	7,672	88,282	1,001,014	66.00
67.00	06700	OCCUPATIONAL THERAPY	236,793	0	0	22,676	259,469	67.00
68.00	06800	SPEECH PATHOLOGY	75,827	0	0	7,262	83,089	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	727,923	0	0	0	727,923	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	834,749	0	0	0	834,749	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,206,175	0	0	7,201	2,213,376	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	10,657	0	0	916	11,573	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,311,318	9,078	28,803	120,254	1,469,453	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,117,851	6,296	154,308	201,807	2,480,262	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	35,108,209	206,281	706,709	1,806,608	35,091,060	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	95,759	0	886	7,761	104,406	192.00
194.00	07950	OCC HEALTH	0	489	0	0	489	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	80,030	0	0	3	80,033	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	431,150	0	0	486	431,636	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	141,927	0	0	7,524	149,451	194.07
194.08	07958	AUTISM CENTER	66,741	0	0	0	66,741	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
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)	35,923,816	206,770	707,595	1,822,382	35,923,816	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/19/2017 9:13 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,090,089					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	702,234	0	2,086,580			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	91,937	0	16,797	289,973		8.00
9.00	00900	HOUSEKEEPING	215,780	0	13,673	43	654,873	9.00
10.00	01000	DIETARY	100,677	0	130,638	0	41,608	10.00
11.00	01100	CAFETERIA	113,950	0	29,642	0	9,441	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	115,343	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,714	0	50,872	1,132	16,203	14.00
15.00	01500	PHARMACY	348,259	0	30,844	0	9,824	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	574	0	17,037	0	5,426	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,695,266	0	671,884	88,036	213,995	30.00
43.00	04300	NURSERY	80,108	0	2,724	4,769	868	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	562,393	0	255,936	46,580	81,516	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	333,164	0	0	19,857	0	52.00
53.00	05300	ANESTHESIOLOGY	279,454	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	916,325	0	320,774	16,154	102,167	54.00
60.00	06000	LABORATORY	1,075,855	0	48,602	0	15,480	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	428,172	0	35,944	17,263	11,448	65.00
66.00	06600	PHYSICAL THERAPY	507,782	0	222,288	0	70,799	66.00
67.00	06700	OCCUPATIONAL THERAPY	131,620	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	42,148	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	369,252	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	423,441	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,122,775	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	5,871	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	745,406	0	136,727	85,598	43,548	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,258,158	0	94,828	3,929	30,203	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,667,658	0	2,079,210	283,361	652,526	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	52,962	0	0	6,612	0	192.00
194.00	07950	OCC HEALTH	248	0	7,370	0	2,347	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	40,598	0	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	218,955	0	0	0	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	75,812	0	0	0	0	194.07
194.08	07958	AUTISM CENTER	33,856	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
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)	12,090,089	0	2,086,580	289,973	654,873	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/19/2017 9:13 am

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	471,393					10.00
11.00	01100	CAFETERIA	0	377,667				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	5,215	0	347,938		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	73,299	14.00
15.00	01500	PHARMACY	0	10,395	0	0	878	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	471,393	96,661	0	177,912	5,670	30.00
43.00	04300	NURSERY	0	4,268	0	7,855	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	30,885	0	56,845	9,212	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,768	0	32,702	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	31,622	0	0	1,698	54.00
60.00	06000	LABORATORY	0	0	0	0	27	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	23,216	0	0	2,430	65.00
66.00	06600	PHYSICAL THERAPY	0	23,617	0	0	835	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,144	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,288	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	41,869	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,025	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	50	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	39,457	0	72,624	3,575	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	73,866	0	0	4,772	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	471,393	366,402	0	347,938	73,041	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,546	0	0	231	192.00
194.00	07950	OCC HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	2,083	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	201	0	0	27	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	5,435	0	0	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
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)	471,393	377,667	0	347,938	73,299	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/19/2017 9:13 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,086,738					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	24,168				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,344	0	0	0	30.00
43.00	04300	NURSERY	0	136	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,241	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	579	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	526	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,050	0	0	0	54.00
60.00	06000	LABORATORY	0	2,510	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	831	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	628	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	178	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	56	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	146	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,647	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	925	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,086,738	2,107	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	35	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	3,053	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,176	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,086,738	24,168	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCC HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	0	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	0	0	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,086,738	24,168	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 5/19/2017 9:13 am

		Cost Center Description	INTERNS & RESIDENTS					
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			21.00	22.00	23.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	6,764,111	0	30.00
43.00	04300	NURSERY	0	0	0	258,648	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	2,155,279	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,060,852	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	830,881	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,200,182	0	54.00
60.00	06000	LABORATORY	0	0	0	3,263,354	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,363,378	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,826,963	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	398,411	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	127,581	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	146	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,140,691	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,259,115	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,427,021	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	17,529	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	2,599,441	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	3,947,194	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	34,640,777	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	167,757	0	192.00
194.00	07950	OCC HEALTH	0	0	0	10,454	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	0	0	122,714	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0	650,819	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	0	230,698	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	100,597	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	0	0	35,923,816	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I | Date/Time Prepared: 5/19/2017 9:13 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	6,764,111		30.00
43.00	04300	NURSERY	258,648		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,155,279		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,060,852		52.00
53.00	05300	ANESTHESIOLOGY	830,881		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,200,182		54.00
60.00	06000	LABORATORY	3,263,354		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62.30
65.00	06500	RESPIRATORY THERAPY	1,363,378		65.00
66.00	06600	PHYSICAL THERAPY	1,826,963		66.00
67.00	06700	OCCUPATIONAL THERAPY	398,411		67.00
68.00	06800	SPEECH PATHOLOGY	127,581		68.00
69.00	06900	ELECTROCARDIOLOGY	146		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,140,691		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,259,115		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,427,021		73.00
76.97	07697	CARDIAC REHABILITATION	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	17,529		76.98
76.99	07699	LITHOTRIPSY	0		76.99
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	2,599,441		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	3,947,194		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	34,640,777		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	167,757		192.00
194.00	07950	OCC HEALTH	10,454		194.00
194.01	07951	PAIN CLINIC	0		194.01
194.02	07952	OCC HEALTH	0		194.02
194.03	07953	FOUNDATIO	122,714		194.03
194.04	07954	KIDS CAMPUS	0		194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	650,819		194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0		194.06
194.07	07957	MISC CATERING	230,698		194.07
194.08	07958	AUTISM CENTER	100,597		194.08
194.09	07959	HUNTINGTON BUA	0		194.09
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	35,923,816		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/19/2017 9:13 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	234	0	234	234	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,974,536	13,618	10,647	1,998,801	75	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	54,384	24,332	78,716	5	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,115	0	1,115	0	8.00
9.00	00900	HOUSEKEEPING	0	908	0	908	4	9.00
10.00	01000	DIETARY	0	8,673	1,642	10,315	1	10.00
11.00	01100	CAFETERIA	0	1,968	0	1,968	3	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	3	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,378	0	3,378	0	14.00
15.00	01500	PHARMACY	0	2,048	60,742	62,790	7	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,131	0	1,131	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	44,609	85,899	130,508	36	30.00
43.00	04300	NURSERY	0	181	0	181	2	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	16,992	107,852	124,844	12	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	7	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,297	193,253	214,550	12	54.00
60.00	06000	LABORATORY	0	3,227	0	3,227	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,386	31,559	33,945	9	65.00
66.00	06600	PHYSICAL THERAPY	0	14,758	7,672	22,430	11	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	3	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	9,078	28,803	37,881	15	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	6,296	154,308	160,604	25	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,974,536	206,281	706,709	2,887,526	232	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	886	886	1	192.00
194.00	07950	OCC HEALTH	0	489	0	489	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	0	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	0	0	1	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
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)	1,974,536	206,770	707,595	2,888,901	234	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/19/2017 9:13 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,998,876					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	116,102	0	194,823			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,200	0	1,568	17,883		8.00
9.00	00900	HOUSEKEEPING	35,676	0	1,277	3	37,868	9.00
10.00	01000	DIETARY	16,645	0	12,198	0	2,406	10.00
11.00	01100	CAFETERIA	18,840	0	2,768	0	546	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	19,070	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	283	0	4,750	70	937	14.00
15.00	01500	PHARMACY	57,579	0	2,880	0	568	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	95	0	1,591	0	314	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	280,273	0	62,732	5,428	12,374	30.00
43.00	04300	NURSERY	13,244	0	254	294	50	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	92,982	0	23,897	2,873	4,714	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	55,083	0	0	1,225	0	52.00
53.00	05300	ANESTHESIOLOGY	46,203	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	151,498	0	29,951	996	5,908	54.00
60.00	06000	LABORATORY	177,874	0	4,538	0	895	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	70,791	0	3,356	1,065	662	65.00
66.00	06600	PHYSICAL THERAPY	83,953	0	20,755	0	4,094	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,761	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,969	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	61,049	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	70,009	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	185,631	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	971	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	123,240	0	12,766	5,279	2,518	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	208,015	0	8,854	242	1,746	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,929,036	0	194,135	17,475	37,732	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,756	0	0	408	0	192.00
194.00	07950	OCC HEALTH	41	0	688	0	136	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	6,712	0	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	36,200	0	0	0	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	12,534	0	0	0	0	194.07
194.08	07958	AUTISM CENTER	5,597	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,998,876	0	194,823	17,883	37,868	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/19/2017 9:13 am

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	41,565					10.00
11.00	01100	CAFETERIA	0	24,125				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	333	0	19,406		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	9,418	14.00
15.00	01500	PHARMACY	0	664	0	0	113	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,565	6,175	0	9,923	728	30.00
43.00	04300	NURSERY	0	273	0	438	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,973	0	3,170	1,184	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,135	0	1,824	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,020	0	0	218	54.00
60.00	06000	LABORATORY	0	0	0	0	3	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,483	0	0	312	65.00
66.00	06600	PHYSICAL THERAPY	0	1,509	0	0	107	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	456	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	146	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	5,382	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	260	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	6	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	2,521	0	4,051	459	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	4,718	0	0	613	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	41,565	23,406	0	19,406	9,385	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	226	0	0	30	192.00
194.00	07950	OCC HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	133	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	13	0	0	3	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	347	0	0	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
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)	41,565	24,125	0	19,406	9,418	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/19/2017 9:13 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	124,601					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,131				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	171	0			30.00
43.00	04300	NURSERY	0	17	0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	413	0			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	74	0			52.00
53.00	05300	ANESTHESIOLOGY	0	67	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	694	0			54.00
60.00	06000	LABORATORY	0	320	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	106	0			65.00
66.00	06600	PHYSICAL THERAPY	0	80	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	23	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	7	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	19	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	210	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	118	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	124,601	269	0			73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	4	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	389	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	150	0			95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	124,601	3,131	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
194.00	07950	OCC HEALTH	0	0	0			194.00
194.01	07951	PAIN CLINIC	0	0	0			194.01
194.02	07952	OCC HEALTH	0	0	0			194.02
194.03	07953	FOUNDATIO	0	0	0			194.03
194.04	07954	KIDS CAMPUS	0	0	0			194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0			194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0			194.06
194.07	07957	MISC CATERING	0	0	0			194.07
194.08	07958	AUTISM CENTER	0	0	0			194.08
194.09	07959	HUNTINGTON BUA	0	0	0			194.09
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	124,601	3,131	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 5/19/2017 9:13 am

		Cost Center Description	INTERNS & RESIDENTS					
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			21.00	22.00	23.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				549,913	0	30.00
43.00	04300	NURSERY				14,753	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM				256,062	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				59,348	0	52.00
53.00	05300	ANESTHESIOLOGY				46,270	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				405,847	0	54.00
60.00	06000	LABORATORY				186,857	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				111,729	0	65.00
66.00	06600	PHYSICAL THERAPY				132,939	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				22,243	0	67.00
68.00	06800	SPEECH PATHOLOGY				7,123	0	68.00
69.00	06900	ELECTROCARDIOLOGY				19	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				66,641	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				70,127	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				310,762	0	73.00
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				981	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY				189,119	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				384,967	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	2,815,700	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES				10,307	0	192.00
194.00	07950	OCC HEALTH				1,354	0	194.00
194.01	07951	PAIN CLINIC				0	0	194.01
194.02	07952	OCC HEALTH				0	0	194.02
194.03	07953	FOUNDATIO				6,845	0	194.03
194.04	07954	KIDS CAMPUS				0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES				36,216	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE				0	0	194.06
194.07	07957	MISC CATERING				12,882	0	194.07
194.08	07958	AUTISM CENTER				5,597	0	194.08
194.09	07959	HUNTINGTON BUA				0	0	194.09
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	0	0	2,888,901	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II | Date/Time Prepared: 5/19/2017 9:13 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	549,913		30.00
43.00	04300	NURSERY	14,753		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	256,062		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	59,348		52.00
53.00	05300	ANESTHESIOLOGY	46,270		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	405,847		54.00
60.00	06000	LABORATORY	186,857		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62.30
65.00	06500	RESPIRATORY THERAPY	111,729		65.00
66.00	06600	PHYSICAL THERAPY	132,939		66.00
67.00	06700	OCCUPATIONAL THERAPY	22,243		67.00
68.00	06800	SPEECH PATHOLOGY	7,123		68.00
69.00	06900	ELECTROCARDIOLOGY	19		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	66,641		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	70,127		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	310,762		73.00
76.97	07697	CARDIAC REHABILITATION	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	981		76.98
76.99	07699	LITHOTRIPSY	0		76.99
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	189,119		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	384,967		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,815,700		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,307		192.00
194.00	07950	OCC HEALTH	1,354		194.00
194.01	07951	PAIN CLINIC	0		194.01
194.02	07952	OCC HEALTH	0		194.02
194.03	07953	FOUNDATIO	6,845		194.03
194.04	07954	KIDS CAMPUS	0		194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	36,216		194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0		194.06
194.07	07957	MISC CATERING	12,882		194.07
194.08	07958	AUTISM CENTER	5,597		194.08
194.09	07959	HUNTINGTON BUA	0		194.09
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	2,888,901		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/19/2017 9:13 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	116,622					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		767,040				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	132	0	17,476,510			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,681	11,541	5,308,256	-12,090,089	23,833,727	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	30,673	26,376	349,917	0	1,384,346	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	629	0	29,633	0	181,239	8.00
9.00	00900	HOUSEKEEPING	512	0	307,376	0	425,377	9.00
10.00	01000	DIETARY	4,892	1,780	71,499	0	198,470	10.00
11.00	01100	CAFETERIA	1,110	0	213,772	0	224,634	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	210,106	0	227,380	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,905	0	0	0	3,378	14.00
15.00	01500	PHARMACY	1,155	65,845	543,828	0	686,538	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	638	0	0	0	1,131	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,160	93,115	2,763,334	0	3,341,950	30.00
43.00	04300	NURSERY	102	0	129,110	0	157,920	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,584	116,913	948,310	0	1,108,671	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	537,578	0	656,782	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	550,901	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,012	209,490	951,333	0	1,806,392	54.00
60.00	06000	LABORATORY	1,820	0	0	0	2,120,880	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,346	34,210	661,078	0	844,074	65.00
66.00	06600	PHYSICAL THERAPY	8,324	8,316	846,614	0	1,001,014	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	217,465	0	259,469	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	69,638	0	83,089	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	727,923	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	834,749	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	69,054	0	2,213,376	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	8,789	0	11,573	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,120	31,223	1,153,225	0	1,469,453	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,551	167,271	1,935,314	0	2,480,262	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	116,346	766,080	17,325,229	-12,090,089	23,000,971	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	960	74,431	0	104,406	192.00
194.00	07950	OCC HEALTH	276	0	0	0	489	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	0	29	0	80,033	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	4,662	0	431,636	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	72,159	0	149,451	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	66,741	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
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)	206,770	707,595	1,822,382		12,090,089	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.772993	0.922501	0.104276		0.507268	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/19/2017 9:13 am

		Cost Center Description	CAPITAL RELATED COSTS			Reconciliation		
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)		ADMINISTRATIVE & GENERAL (ACCUM COST)	
			1.00	2.00	4.00	5A	5.00	
204.00		Cost to be allocated (per Wkst. B, Part II)			234		1,998,876	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000013		0.083868	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/19/2017 9:13 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	78,136				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	629	256,999			8.00
9.00	00900	HOUSEKEEPING	0	512	38	76,995		9.00
10.00	01000	DIETARY	0	4,892	0	4,892	27,536	10.00
11.00	01100	CAFETERIA	0	1,110	0	1,110	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,905	1,003	1,905	0	14.00
15.00	01500	PHARMACY	0	1,155	0	1,155	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	638	0	638	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	25,160	78,026	25,160	27,536	30.00
43.00	04300	NURSERY	0	102	4,227	102	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	9,584	41,283	9,584	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	17,599	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,012	14,317	12,012	0	54.00
60.00	06000	LABORATORY	0	1,820	0	1,820	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,346	15,300	1,346	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,324	0	8,324	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	5,120	75,864	5,120	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,551	3,482	3,551	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	77,860	251,139	76,719	27,536	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	5,860	0	0	192.00
194.00	07950	OCC HEALTH	0	276	0	276	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	0	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	0	0	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
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)	0	2,086,580	289,973	654,873	471,393	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	26.704464	1.128304	8.505396	17.119153	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	194,823	17,883	37,868	41,565	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/19/2017 9:13 am

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	2.493383	0.069584	0.491824	1.509479	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/19/2017 9:13 am

		Cost Center Description	CAFETERIA (HOURS OF SERVICE)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	377,061					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	5,207	0	188,736			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	2,735,871		14.00
15.00	01500	PHARMACY	10,378	0	0	32,767	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	96,507	0	96,507	211,612	0	30.00
43.00	04300	NURSERY	4,261	0	4,261	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,835	0	30,835	343,841	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,739	0	17,739	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,571	0	0	63,370	0	54.00
60.00	06000	LABORATORY	0	0	0	1,002	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	23,179	0	0	90,716	0	65.00
66.00	06600	PHYSICAL THERAPY	23,579	0	0	31,167	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,133	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,284	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,562,754	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	75,589	100	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	1,868	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	39,394	0	39,394	133,434	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	73,747	0	0	178,118	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	365,814	0	188,736	2,726,238	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,540	0	0	8,618	0	192.00
194.00	07950	OCC HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	2,080	0	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	201	0	0	1,015	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	5,426	0	0	0	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
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)	377,667	0	347,938	73,299	1,086,738	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.001607	0.000000	1.843517	0.026792	10,867.380000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	24,125	0	19,406	9,418	124,601	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/19/2017 9:13 am

	Cost Center Description	CAFETERIA (HOURS OF SERVICE)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.063982	0.000000	0.102821	0.003442	1,246.010000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/19/2017 9:13 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	162,369,521					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,022,964	0	0	0	0	30.00
43.00	04300	NURSERY	910,329	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,748,743	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,884,031	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,531,192	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,061,645	0	0	0	0	54.00
60.00	06000	LABORATORY	16,842,513	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	5,578,080	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,212,614	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,197,366	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	377,097	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	981,907	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,054,476	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,208,274	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,143,133	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	232,789	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	20,493,059	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	7,889,309	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	162,369,521	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCC HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATIO	0	0	0	0	0	194.03
194.04	07954	KIDS CAMPUS	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0	0	0	0	194.06
194.07	07957	MISC CATERING	0	0	0	0	0	194.07
194.08	07958	AUTISM CENTER	0	0	0	0	0	194.08
194.09	07959	HUNTINGTON BUA	0	0	0	0	0	194.09
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)	24,168	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000149	0.000000	0.000000	0.000000	0.000000	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/19/2017 9:13 am

	Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
		16.00	17.00	19.00	20.00	21.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	3,131	0	0	0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000019	0.000000	0.000000	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/19/2017 9:13 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)		
			22.00	23.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00	02000	NURSING SCHOOL				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
43.00	04300	NURSERY	0	0		43.00
		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	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OCC HEALTH	0	0		194.00
194.01	07951	PAIN CLINIC	0	0		194.01
194.02	07952	OCC HEALTH	0	0		194.02
194.03	07953	FOUNDATIO	0	0		194.03
194.04	07954	KIDS CAMPUS	0	0		194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0		194.05
194.06	07956	HUNTINGTON COLLEGE NURSE	0	0		194.06
194.07	07957	MISC CATERING	0	0		194.07
194.08	07958	AUTISM CENTER	0	0		194.08
194.09	07959	HUNTINGTON BUA	0	0		194.09
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)	0	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000		203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 5/19/2017 9:13 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)					
			22.00	23.00					
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0					204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000					205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/19/2017 9:13 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,764,111		6,764,111	0	6,764,111	30.00
43.00	04300	NURSERY	258,648		258,648	0	258,648	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,155,279		2,155,279	2,017	2,157,296	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,060,852		1,060,852	0	1,060,852	52.00
53.00	05300	ANESTHESIOLOGY	830,881		830,881	0	830,881	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,200,182		3,200,182	0	3,200,182	54.00
60.00	06000	LABORATORY	3,263,354		3,263,354	0	3,263,354	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,363,378	0	1,363,378	0	1,363,378	65.00
66.00	06600	PHYSICAL THERAPY	1,826,963	0	1,826,963	0	1,826,963	66.00
67.00	06700	OCCUPATIONAL THERAPY	398,411	0	398,411	0	398,411	67.00
68.00	06800	SPEECH PATHOLOGY	127,581	0	127,581	0	127,581	68.00
69.00	06900	ELECTROCARDIOLOGY	146		146	0	146	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,140,691		1,140,691	0	1,140,691	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,259,115		1,259,115	0	1,259,115	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,427,021		4,427,021	0	4,427,021	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	17,529		17,529	0	17,529	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,599,441		2,599,441	0	2,599,441	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,457,582		1,457,582		1,457,582	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,947,194		3,947,194	0	3,947,194	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	36,098,359	0	36,098,359	2,017	36,100,376	200.00
201.00		Less Observation Beds	1,457,582		1,457,582		1,457,582	201.00
202.00		Total (see instructions)	34,640,777	0	34,640,777	2,017	34,642,794	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/19/2017 9:13 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,456,512		7,456,512			30.00
43.00	04300	NURSERY	910,329		910,329			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,220,194	15,528,549	21,748,743	0.099099	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,884,031	0	3,884,031	0.273132	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	703,888	2,827,304	3,531,192	0.235298	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,222,014	30,839,631	34,061,645	0.093953	0.000000	54.00
60.00	06000	LABORATORY	2,989,066	13,853,447	16,842,513	0.193757	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	1,294,679	4,283,401	5,578,080	0.244417	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	555,703	3,656,911	4,212,614	0.433689	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	93,481	1,103,885	1,197,366	0.332740	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	24,055	353,042	377,097	0.338324	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	685,038	296,869	981,907	0.000149	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,413,122	8,641,354	11,054,476	0.103188	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,058,524	1,149,750	6,208,274	0.202812	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,789,243	9,353,890	14,143,133	0.313016	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	119,730	113,059	232,789	0.075300	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,402,958	18,090,101	20,493,059	0.126845	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,566,452	1,566,452	0.930499	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	7,889,309	7,889,309	0.500322	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	42,822,567	119,546,954	162,369,521			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	42,822,567	119,546,954	162,369,521			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/19/2017 9:13 am

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.099192	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.273132	52.00
53.00	05300	ANESTHESIOLOGY	0.235298	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.093953	54.00
60.00	06000	LABORATORY	0.193757	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0.244417	65.00
66.00	06600	PHYSICAL THERAPY	0.433689	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.332740	67.00
68.00	06800	SPEECH PATHOLOGY	0.338324	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000149	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.103188	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.202812	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313016	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.075300	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.126845	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.930499	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.500322	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/19/2017 9:13 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,764,111		6,764,111	0	6,764,111	30.00
43.00	04300	NURSERY	258,648		258,648	0	258,648	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,155,279		2,155,279	2,017	2,157,296	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,060,852		1,060,852	0	1,060,852	52.00
53.00	05300	ANESTHESIOLOGY	830,881		830,881	0	830,881	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,200,182		3,200,182	0	3,200,182	54.00
60.00	06000	LABORATORY	3,263,354		3,263,354	0	3,263,354	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,363,378	0	1,363,378	0	1,363,378	65.00
66.00	06600	PHYSICAL THERAPY	1,826,963	0	1,826,963	0	1,826,963	66.00
67.00	06700	OCCUPATIONAL THERAPY	398,411	0	398,411	0	398,411	67.00
68.00	06800	SPEECH PATHOLOGY	127,581	0	127,581	0	127,581	68.00
69.00	06900	ELECTROCARDIOLOGY	146		146	0	146	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,140,691		1,140,691	0	1,140,691	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,259,115		1,259,115	0	1,259,115	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,427,021		4,427,021	0	4,427,021	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	17,529		17,529	0	17,529	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,599,441		2,599,441	0	2,599,441	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,457,582		1,457,582		1,457,582	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,947,194		3,947,194	0	3,947,194	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	36,098,359	0	36,098,359	2,017	36,100,376	200.00
201.00		Less Observation Beds	1,457,582		1,457,582		1,457,582	201.00
202.00		Total (see instructions)	34,640,777	0	34,640,777	2,017	34,642,794	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/19/2017 9:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,456,512		7,456,512			30.00
43.00	04300	NURSERY	910,329		910,329			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,220,194	15,528,549	21,748,743	0.099099	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,884,031	0	3,884,031	0.273132	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	703,888	2,827,304	3,531,192	0.235298	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,222,014	30,839,631	34,061,645	0.093953	0.000000	54.00
60.00	06000	LABORATORY	2,989,066	13,853,447	16,842,513	0.193757	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	1,294,679	4,283,401	5,578,080	0.244417	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	555,703	3,656,911	4,212,614	0.433689	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	93,481	1,103,885	1,197,366	0.332740	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	24,055	353,042	377,097	0.338324	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	685,038	296,869	981,907	0.000149	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,413,122	8,641,354	11,054,476	0.103188	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,058,524	1,149,750	6,208,274	0.202812	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,789,243	9,353,890	14,143,133	0.313016	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	119,730	113,059	232,789	0.075300	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,402,958	18,090,101	20,493,059	0.126845	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,566,452	1,566,452	0.930499	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	7,889,309	7,889,309	0.500322	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	42,822,567	119,546,954	162,369,521			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	42,822,567	119,546,954	162,369,521			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 5/19/2017 9:13 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.099192		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.273132		52.00
53.00	05300	ANESTHESIOLOGY	0.235298		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.093953		54.00
60.00	06000	LABORATORY	0.193757		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.244417		65.00
66.00	06600	PHYSICAL THERAPY	0.433689		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.332740		67.00
68.00	06800	SPEECH PATHOLOGY	0.338324		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000149		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.103188		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.202812		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313016		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.075300		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.126845		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.930499		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.500322		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part II Date/Time Prepared: 5/19/2017 9:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,155,279	256,062	1,899,217	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,060,852	59,348	1,001,504	0	0	52.00
53.00	05300	ANESTHESIOLOGY	830,881	46,270	784,611	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,200,182	405,847	2,794,335	0	0	54.00
60.00	06000	LABORATORY	3,263,354	186,857	3,076,497	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,363,378	111,729	1,251,649	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,826,963	132,939	1,694,024	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	398,411	22,243	376,168	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	127,581	7,123	120,458	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	146	19	127	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,140,691	66,641	1,074,050	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,259,115	70,127	1,188,988	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,427,021	310,762	4,116,259	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	17,529	981	16,548	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,599,441	189,119	2,410,322	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,457,582	118,500	1,339,082	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,947,194	384,967	3,562,227	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	29,075,600	2,369,534	26,706,066	0	0	200.00
201.00		Less Observation Beds	1,457,582	118,500	1,339,082	0	0	201.00
202.00		Total (line 200 minus line 201)	27,618,018	2,251,034	25,366,984	0	0	202.00

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

Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part II Date/Time Prepared: 5/19/2017 9:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,155,279	21,748,743	0.099099		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,060,852	3,884,031	0.273132		52.00
53.00	05300	ANESTHESIOLOGY	830,881	3,531,192	0.235298		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,200,182	34,061,645	0.093953		54.00
60.00	06000	LABORATORY	3,263,354	16,842,513	0.193757		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	1,363,378	5,578,080	0.244417		65.00
66.00	06600	PHYSICAL THERAPY	1,826,963	4,212,614	0.433689		66.00
67.00	06700	OCCUPATIONAL THERAPY	398,411	1,197,366	0.332740		67.00
68.00	06800	SPEECH PATHOLOGY	127,581	377,097	0.338324		68.00
69.00	06900	ELECTROCARDIOLOGY	146	981,907	0.000149		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,140,691	11,054,476	0.103188		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,259,115	6,208,274	0.202812		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,427,021	14,143,133	0.313016		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	17,529	232,789	0.075300		76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000		76.99
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	2,599,441	20,493,059	0.126845		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,457,582	1,566,452	0.930499		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	3,947,194	7,889,309	0.500322		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	29,075,600	154,002,680			200.00
201.00		Less Observation Beds	1,457,582	0			201.00
202.00		Total (line 200 minus line 201)	27,618,018	154,002,680			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part I Date/Time Prepared: 5/19/2017 9:13 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	549,913	0	549,913	5,527	99.50	30.00
43.00	NURSERY	14,753		14,753	748	19.72	43.00
200.00	Total (lines 30-199)	564,666		564,666	6,275		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,633	162,484				30.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30-199)	1,633	162,484				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/19/2017 9:13 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	256,062	21,748,743	0.011774	1,738,470	20,469	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	59,348	3,884,031	0.015280	0	0	52.00
53.00	05300	ANESTHESIOLOGY	46,270	3,531,192	0.013103	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	405,847	34,061,645	0.011915	1,273,204	15,170	54.00
60.00	06000	LABORATORY	186,857	16,842,513	0.011094	1,124,640	12,477	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	111,729	5,578,080	0.020030	581,765	11,653	65.00
66.00	06600	PHYSICAL THERAPY	132,939	4,212,614	0.031557	291,675	9,204	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,243	1,197,366	0.018577	48,637	904	67.00
68.00	06800	SPEECH PATHOLOGY	7,123	377,097	0.018889	12,391	234	68.00
69.00	06900	ELECTROCARDIOLOGY	19	981,907	0.000019	329,511	6	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	66,641	11,054,476	0.006028	575,610	3,470	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	70,127	6,208,274	0.011296	1,822,183	20,583	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	310,762	14,143,133	0.021973	1,720,213	37,798	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	981	232,789	0.004214	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	189,119	20,493,059	0.009228	1,025,012	9,459	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	118,500	1,566,452	0.075649	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,984,567	146,113,371		10,543,311	141,427	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 5/19/2017 9:13 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,527	0.00	1,633	0		30.00
43.00	04300	NURSERY	748	0.00	0	0		43.00
200.00		Total (lines 30-199)	6,275		1,633	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/19/2017 9:13 am

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		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/19/2017 9:13 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	21,748,743	0.000000	0.000000	1,738,470	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,884,031	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	3,531,192	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,061,645	0.000000	0.000000	1,273,204	54.00
60.00	06000	LABORATORY	0	16,842,513	0.000000	0.000000	1,124,640	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	5,578,080	0.000000	0.000000	581,765	65.00
66.00	06600	PHYSICAL THERAPY	0	4,212,614	0.000000	0.000000	291,675	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,197,366	0.000000	0.000000	48,637	67.00
68.00	06800	SPEECH PATHOLOGY	0	377,097	0.000000	0.000000	12,391	68.00
69.00	06900	ELECTROCARDIOLOGY	0	981,907	0.000000	0.000000	329,511	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,054,476	0.000000	0.000000	575,610	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,208,274	0.000000	0.000000	1,822,183	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,143,133	0.000000	0.000000	1,720,213	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	232,789	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	20,493,059	0.000000	0.000000	1,025,012	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,566,452	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	146,113,371			10,543,311	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/19/2017 9:13 am

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		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	3,352,756	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,747,456	0		54.00
60.00	06000	LABORATORY	0	298,830	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	795,982	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	119,067	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	429,384	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	120,003	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	192,722	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	921	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	3,348,687	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	812,988	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	16,218,796	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/19/2017 9:13 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.099099	3,352,756	0	0	332,255	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.273132	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.235298	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.093953	6,747,456	0	0	633,944	54.00
60.00	06000	LABORATORY	0.193757	298,830	0	0	57,900	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.244417	795,982	0	0	194,552	65.00
66.00	06600	PHYSICAL THERAPY	0.433689	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.332740	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.338324	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000149	119,067	0	0	18	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.103188	429,384	0	0	44,307	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.202812	120,003	0	0	24,338	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313016	192,722	0	0	60,325	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.075300	921	0	0	69	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.126845	3,348,687	0	0	424,764	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.930499	812,988	0	0	756,485	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.500322		0			95.00
200.00		Subtotal (see instructions)		16,218,796	0	0	2,528,957	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		16,218,796	0	0	2,528,957	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/19/2017 9:13 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part I Date/Time Prepared: 5/19/2017 9:13 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	549,913	0	549,913	5,527	99.50	30.00
43.00	NURSERY	14,753		14,753	748	19.72	43.00
200.00	Total (lines 30-199)	564,666		564,666	6,275		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	51	5,075	30.00
43.00	NURSERY	35	690	43.00
200.00	Total (lines 30-199)	86	5,765	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 5/19/2017 9:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	256,062	21,748,743	0.011774	2,410,739	28,384	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	59,348	3,884,031	0.015280	0	0	52.00
53.00	05300	ANESTHESIOLOGY	46,270	3,531,192	0.013103	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	405,847	34,061,645	0.011915	360,061	4,290	54.00
60.00	06000	LABORATORY	186,857	16,842,513	0.011094	528,870	5,867	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	111,729	5,578,080	0.020030	178,189	3,569	65.00
66.00	06600	PHYSICAL THERAPY	132,939	4,212,614	0.031557	23,349	737	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,243	1,197,366	0.018577	3,575	66	67.00
68.00	06800	SPEECH PATHOLOGY	7,123	377,097	0.018889	1,224	23	68.00
69.00	06900	ELECTROCARDIOLOGY	19	981,907	0.000019	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	66,641	11,054,476	0.006028	241,373	1,455	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	70,127	6,208,274	0.011296	295,710	3,340	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	310,762	14,143,133	0.021973	832,266	18,287	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	981	232,789	0.004214	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	189,119	20,493,059	0.009228	319,070	2,944	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	118,500	1,566,452	0.075649	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,984,567	146,113,371		5,194,426	68,962	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 5/19/2017 9:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,527	0.00	51	0		30.00
43.00	04300	NURSERY	748	0.00	35	0		43.00
200.00		Total (lines 30-199)	6,275		86	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/19/2017 9:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 5/19/2017 9:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	21,748,743	0.000000	0.000000	2,410,739	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,884,031	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	3,531,192	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,061,645	0.000000	0.000000	360,061	54.00
60.00	06000	LABORATORY	0	16,842,513	0.000000	0.000000	528,870	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	5,578,080	0.000000	0.000000	178,189	65.00
66.00	06600	PHYSICAL THERAPY	0	4,212,614	0.000000	0.000000	23,349	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,197,366	0.000000	0.000000	3,575	67.00
68.00	06800	SPEECH PATHOLOGY	0	377,097	0.000000	0.000000	1,224	68.00
69.00	06900	ELECTROCARDIOLOGY	0	981,907	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,054,476	0.000000	0.000000	241,373	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,208,274	0.000000	0.000000	295,710	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,143,133	0.000000	0.000000	832,266	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	232,789	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	20,493,059	0.000000	0.000000	319,070	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,566,452	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	146,113,371			5,194,426	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 5/19/2017 9:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/19/2017 9:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.099099	0	7,145,521	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.273132	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.235298	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.093953	0	5,894,091	0	0	54.00
60.00	06000	LABORATORY	0.193757	0	2,825,165	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.244417	0	475,995	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.433689	0	784,102	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.332740	0	398,972	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.338324	0	177,132	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000149	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.103188	0	609,022	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.202812	0	206,806	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313016	0	1,286,156	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.075300	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.126845	0	5,752,526	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.930499	0	36,039	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.500322	0	1,255,441			95.00
200.00		Subtotal (see instructions)		0	26,846,968	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	26,846,968	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 5/19/2017 9:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	708,114	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	553,768	0		54.00
60.00	06000	LABORATORY	547,395	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	116,341	0		65.00
66.00	06600	PHYSICAL THERAPY	340,056	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	132,754	0		67.00
68.00	06800	SPEECH PATHOLOGY	59,928	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	62,844	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	41,943	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	402,587	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	729,679	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	33,534	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	628,125			95.00
200.00		Subtotal (see instructions)	4,357,068	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,357,068	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/19/2017 9:13 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,527	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,527	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,336	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,633	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,764,111	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,764,111	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,764,111	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,223.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,998,514	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,998,514	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/19/2017 9:13 am

Title XVIII | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,896,512	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,895,026	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	162,484	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	141,427	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	303,911	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,591,115	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,191	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,223.83	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,457,582	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/19/2017 9:13 am

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	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	549,913	6,764,111	0.081299	1,457,582	118,500	90.00
91.00	Nursing School cost	0	6,764,111	0.000000	1,457,582	0	91.00
92.00	Allied health cost	0	6,764,111	0.000000	1,457,582	0	92.00
93.00	All other Medical Education	0	6,764,111	0.000000	1,457,582	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/19/2017 9:13 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,527	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,527	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,336	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	51	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	748	15.00
16.00	Nursery days (title V or XIX only)	35	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,764,111	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,764,111	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,764,111	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,223.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	62,415	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	62,415	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/19/2017 9:13 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	258,648	748	345.79	35	12,103	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	816,575	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	891,093	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	5,765	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	68,962	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	74,727	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	816,366	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,191	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,223.83	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,457,582	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 5/19/2017 9:13 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	549,913	6,764,111	0.081299	1,457,582	118,500	90.00
91.00	Nursing School cost	0	6,764,111	0.000000	1,457,582	0	91.00
92.00	Allied health cost	0	6,764,111	0.000000	1,457,582	0	92.00
93.00	All other Medical Education	0	6,764,111	0.000000	1,457,582	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/19/2017 9:13 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,796,773		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.099192	1,738,470	172,442	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.273132	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.235298	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.093953	1,273,204	119,621	54.00
60.00	06000	LABORATORY	0.193757	1,124,640	217,907	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.244417	581,765	142,193	65.00
66.00	06600	PHYSICAL THERAPY	0.433689	291,675	126,496	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.332740	48,637	16,183	67.00
68.00	06800	SPEECH PATHOLOGY	0.338324	12,391	4,192	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000149	329,511	49	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.103188	575,610	59,396	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.202812	1,822,183	369,561	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313016	1,720,213	538,454	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.075300	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.126845	1,025,012	130,018	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.930499	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		10,543,311	1,896,512	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		10,543,311		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 5/19/2017 9:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,264,447		30.00
43.00	04300	NURSERY		418,532		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.099192	2,410,739	239,126	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.273132	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.235298	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.093953	360,061	33,829	54.00
60.00	06000	LABORATORY	0.193757	528,870	102,472	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.244417	178,189	43,552	65.00
66.00	06600	PHYSICAL THERAPY	0.433689	23,349	10,126	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.332740	3,575	1,190	67.00
68.00	06800	SPEECH PATHOLOGY	0.338324	1,224	414	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000149	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.103188	241,373	24,907	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.202812	295,710	59,974	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313016	832,266	260,513	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.075300	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.126845	319,070	40,472	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.930499	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		5,194,426	816,575	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		5,194,426		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Date/Time Prepared: 5/19/2017 9:13 am

Title XVIII | Hospital | PPS

		Before GEO Reclass	On/After GEO Reclass	
		1.00	1.01	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			
1.00	DRG Amounts Other than Outlier Payments	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,103,567	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	0	801,401	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	0	1.04
2.00	Outlier payments for discharges. (see instructions)	1,104	7,470	2.00
2.01	Outlier reconciliation amount	0	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	0	2.02
3.00	Managed Care Simulated Payments	0	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	32.75		4.00
	Indirect Medical Education Adjustment			
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00		11.00
12.00	Current year allowable FTE (see instructions)	0.00		12.00
13.00	Total allowable FTE count for the prior year.	0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00		15.00
16.00	Adjustment for residents in initial years of the program	0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00		17.00
18.00	Adjusted rolling average FTE count	0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000		21.00
22.00	IME payment adjustment (see instructions)	0	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA			
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)	0	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	0	29.01
	Disproportionate Share Adjustment			
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.73		30.00
31.00	Percentage of Medicaid patient days (see instructions)	27.42		31.00
32.00	Sum of lines 30 and 31	30.15		32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	12.00	33.00
34.00	Disproportionate share adjustment (see instructions)	63,107	24,042	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0091	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/19/2017 9:13 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000051203	0.000049582	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	328,014	296,376	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	245,562	74,703	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	320,265		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00

		Before GEO Reclass	On/After GEO Reclass	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	2,488,043	832,913	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0	0	48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	3,320,956	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	234,643	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	3,555,599	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	3,555,599	61.00
62.00	Deductibles billed to program beneficiaries	473,145	62.00
63.00	Coinsurance billed to program beneficiaries	7,589	63.00
64.00	Allowable bad debts (see instructions)	26,381	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	17,148	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	26,381	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	3,092,013	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	RURAL DEMONSTRATION PROJECT	0	70.50
70.88	SCH or MDH volume decrease adjustment	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	41,238	70.93
70.94	HRR adjustment amount (see instructions)	-2,160	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0091	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/19/2017 9:13 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2016	329,094	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2017	129,118	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		3,589,303	71.00
71.01	Sequestration adjustment (see instructions)		71,786	71.01
72.00	Interim payments		3,483,815	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		33,702	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		183,255	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	1.0142869700	1.0176257790	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.9989	1.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/19/2017 9:13 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,103,567	0	2,103,567		2,103,567	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	801,401	0		801,401	801,401	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	8,574	0	1,103	7,471	8,574	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	87,149	0	63,107	24,042	87,149	11.00
11.01	Uncompensated care payments	36.00	320,265	0	245,562	74,703	320,265	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	3,320,956	0	2,413,339	907,617	3,320,956	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3,320,956	0	2,413,339	907,617	3,320,956	15.00
16.00	Payment for inpatient program capital	50.00	234,643	0	167,788	66,855	234,643	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/19/2017 9:13 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	2,581,127	974,472	3,555,599	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	231,632	0	165,534	66,098	231,632	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	3,011	0	2,254	757	3,011	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	234,643	0	167,788	66,855	234,643	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.127500	0.132500		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			329,094		329,094	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				129,118	129,118	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/19/2017 9:13 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,103,567	2,201,607		2,201,607	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	801,401		838,752	838,752	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	8,574	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	87,149	61,986	25,163	87,149	11.00
11.01	Uncompensated care payments	36.00	320,265	245,562	74,703	320,265	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	3,320,956	2,382,338	938,618	3,320,956	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3,320,956	2,382,338	938,618	3,320,956	15.00
16.00	Payment for inpatient program capital	50.00	234,643	172,913	61,730	234,643	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
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			2,555,251	1,000,348	3,555,599	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/19/2017 9:13 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	231,632	170,659	60,973	231,632	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	3,011	2,254	757	3,011	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	234,643	172,913	61,730	234,643	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	329,094	329,094		329,094	28.00
29.00	Low volume adjustment on or after October 1	70.97	129,118		129,118	129,118	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	41,238	28,053	13,185	41,238	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-2,160	-2,160	0	-2,160	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0091	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/19/2017 9:13 am
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	2,528,957	2.00
3.00	PPS payments	2,428,237	3.00
4.00	Outlier payment (see instructions)	3,834	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.859	5.00
6.00	Line 2 times line 5	2,172,374	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	2,432,071	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	539,586	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,892,485	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,892,485	30.00
31.00	Primary payer payments	878	31.00
32.00	Subtotal (line 30 minus line 31)	1,891,607	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	62,720	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	40,768	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	62,720	36.00
37.00	Subtotal (see instructions)	1,932,375	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,932,375	40.00
40.01	Sequestration adjustment (see instructions)	38,648	40.01
41.00	Interim payments	1,853,781	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	39,946	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 5/19/2017 9:13 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,483,815		1,853,781	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,483,815		1,853,781	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		33,702		39,946	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,517,517		1,893,727	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0091	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/19/2017 9:13 am
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		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1,606	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,633	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	881	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	4,336	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	162,369,521	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	2,506,881	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 5/19/2017 9:13 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2,580	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	18,947,927	0	0	0	4.00
5.00	Other receivable	116,692	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-12,417,925	0	0	0	6.00
7.00	Inventory	272,824	0	0	0	7.00
8.00	Prepaid expenses	-2,840,532	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,081,566	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	531,642	0	0	0	13.00
14.00	Accumulated depreciation	-279,599	0	0	0	14.00
15.00	Buildings	2,316,724	0	0	0	15.00
16.00	Accumulated depreciation	-1,112,475	0	0	0	16.00
17.00	Leasehold improvements	32,500	0	0	0	17.00
18.00	Accumulated depreciation	-30,062	0	0	0	18.00
19.00	Fixed equipment	588,704	0	0	0	19.00
20.00	Accumulated depreciation	-495,462	0	0	0	20.00
21.00	Automobiles and trucks	1,028,900	0	0	0	21.00
22.00	Accumulated depreciation	-626,183	0	0	0	22.00
23.00	Major movable equipment	10,819,322	0	0	0	23.00
24.00	Accumulated depreciation	-8,722,751	0	0	0	24.00
25.00	Minor equipment depreciable	1,083,234	0	0	0	25.00
26.00	Accumulated depreciation	-595,626	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	4,538,868	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	33,692,768	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	623,513	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	34,316,281	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	42,936,715	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,244,730	0	0	0	37.00
38.00	Salaries, wages, and fees payable	817,312	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	41,012	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	-67,477	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,035,577	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	153,700	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	42,267	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	195,967	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,231,544	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	40,705,171				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	40,705,171	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	42,936,715	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 5/19/2017 9:13 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		40,649,594		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		15,624,415				2.00
3.00	Total (sum of line 1 and line 2)		56,274,009		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		56,274,009		0		11.00
12.00	ASSET TRANSFERS	15,568,838		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		15,568,838		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		40,705,171		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0091 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/19/2017 9:13 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,587,265		7,587,265	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7,587,265		7,587,265	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	7,587,265		7,587,265	17.00
18.00	Ancillary services	35,882,334	0	35,882,334	18.00
19.00	Outpatient services	0	119,616,337	119,616,337	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	7,917,288	7,917,288	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	43,469,599	127,533,625	171,003,224	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		44,430,912		29.00
30.00	PROVISION FOR BAD DEBT	5,743,885			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		5,743,885		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		50,174,797		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0091	Period: From 01/01/2016 To 12/31/2016	Worksheet G-3 Date/Time Prepared: 5/19/2017 9:13 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	171,003,224	1.00
2.00	Less contractual allowances and discounts on patients' accounts	109,109,894	2.00
3.00	Net patient revenues (line 1 minus line 2)	61,893,330	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	50,174,797	4.00
5.00	Net income from service to patients (line 3 minus line 4)	11,718,533	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	2,269,943	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	157,322	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.01	GAIN/(LOSS) ON SALE OF CAPITAL ASSET	8,564	24.01
24.02	EMS SUBSIDY	352,080	24.02
24.03	OTHER OPERATING REVENUE	1,117,973	24.03
25.00	Total other income (sum of lines 6-24)	3,905,882	25.00
26.00	Total (line 5 plus line 25)	15,624,415	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	15,624,415	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0091	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 5/19/2017 9:13 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	231,632	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	3,011	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	12.32	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	234,643	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00