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: 15-0101	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 3/30/2017 9:29 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 3/30/2017 Time: 9:29 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 WHITLEY MEMORIAL HOSPITAL (15-0101) 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	-70,384	81,314	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
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	-70,384	81,314	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 3/30/2017 9:09 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1260 E STATE ROAD 205	PO Box:			1.00
2.00	City: COLUMBIA CITY	State: IN	Zip Code: 46725-9492	County: WHITLEY	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	WHITLEY MEMORIAL HOSPITAL	150101	23060	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)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	270	615	0	0	683	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: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 3/30/2017 9:09 am

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

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		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: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I Date/Time Prepared: 3/30/2017 9:09 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:	93,729	188,774	21,039	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part I | Date/Time Prepared: 3/30/2017 9:09 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	15H032	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: 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		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.	N	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)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0101	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 3/30/2017 9:09 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2015	09/30/2016	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: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 3/30/2017 9:09 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/30/2016	Y	04/30/2015	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: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-2 Part II Date/Time Prepared: 3/30/2017 9:09 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.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		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: 15-0101	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 3/30/2017 9:09 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: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 3/30/2017 9:09 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	30	10,980	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)		30	10,980	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)		30	10,980	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	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		30				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: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I | Date/Time Prepared: 3/30/2017 9:09 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)	1,159	132	3,790			1.00
2.00	HMO and other (see instructions)	1,037	1,236				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)	1,159	132	3,790			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		123	882			13.00
14.00	Total (see instructions)	1,159	255	4,672	0.00	263.30	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	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	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	263.30	27.00
28.00	Observation Bed Days		281	1,340			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			93			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	77	131			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: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part I Date/Time Prepared: 3/30/2017 9:09 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	347	225	1,574	1.00
2.00	HMO and other (see instructions)			357	108		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	347	225	1,574	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	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 3/30/2017 9:09 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	16,388,743	3,975,379	20,364,122	558,112.49	36.49	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		84,406	0	84,406	545.00	154.87	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		5,078,116	0	5,078,116	119,673.00	42.43	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,485,117	135,897	1,621,014	74,543.59	21.75	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		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		3,975,379	0	3,975,379	119,673.00	33.22	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)		4,688,292	0	4,688,292			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		467,177	0	467,177			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		1,102,737	0	1,102,737			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	1,633,823	-1,457,130	176,693	5,831.45	30.30	26.00
27.00	Administrative & General	5.00	1,609,519	4,357,589	5,967,108	22,119.02	269.77	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part II Date/Time Prepared: 3/30/2017 9:09 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	420,024	31,154	451,178	18,762.94	24.05	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	390,976	28,999	419,975	33,259.51	12.63	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	405,123	-314,800	90,323	8,659.46	10.43	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	334,683	334,683	22,505.94	14.87	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	214,521	15,911	230,432	6,616.11	34.83	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	523,460	38,826	562,286	12,233.93	45.96	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: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part III Date/Time Prepared: 3/30/2017 9:09 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)		11,310,627	3,975,379	15,286,006	438,439.49	34.86	1.00
2.00	Excluded area salaries (see instructions)		1,485,117	135,897	1,621,014	74,543.59	21.75	2.00
3.00	Subtotal salaries (line 1 minus line 2)		9,825,510	3,839,482	13,664,992	363,895.90	37.55	3.00
4.00	Subtotal other wages & related costs (see inst.)		3,975,379	0	3,975,379	119,673.00	33.22	4.00
5.00	Subtotal wage-related costs (see inst.)		5,791,029	0	5,791,029	0.00	42.38	5.00
6.00	Total (sum of lines 3 thru 5)		19,591,918	3,839,482	23,431,400	483,568.90	48.46	6.00
7.00	Total overhead cost (see instructions)		5,197,446	3,035,232	8,232,678	129,988.36	63.33	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part IV Date/Time Prepared: 3/30/2017 9:09 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	286,984	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	632,577	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	66,513	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	2,880,207	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)	28,178	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)	76,000	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	20,831	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	1,159,373	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))	47,285	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	41,569	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,239,517	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: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-3 Part V Date/Time Prepared: 3/30/2017 9:09 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	5,239,517	1.00
2.00	Hospital	0	5,239,517	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	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet S-10 | Date/Time Prepared: 3/30/2017 9:09 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)	0.245145	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,409,848	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	576,515	5.00
6.00	Medicaid charges	17,355,373	6.00
7.00	Medicaid cost (line 1 times line 6)	4,254,583	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,268,220	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	2,921,059	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	21,017,821	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	5,152,414	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)	2,231,355	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)	4,499,575	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)	225,086	1,851,556	2,076,642	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	55,179	453,900	509,079	21.00
22.00	Partial payment by patients approved for charity care	132	638	770	22.00
23.00	Cost of charity care (line 21 minus line 22)	55,047	453,262	508,309	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	9,581,057	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	88,333	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	9,492,724	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,327,094	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,835,403	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,334,978	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 3/30/2017 9:09 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		3,490,268	3,490,268	-350,267	3,140,001	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		753,386	753,386	1,083,920	1,837,306	2.00
3.00	00300	OTHER CAP REL COSTS		97,000	97,000	-97,000	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,633,823	5,213,336	6,847,159	-1,457,130	5,390,029	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,609,519	15,009,842	16,619,361	-44,107	16,575,254	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	420,024	1,072,714	1,492,738	-67,239	1,425,499	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	213,377	213,377	0	213,377	8.00
9.00	00900	HOUSEKEEPING	390,976	171,349	562,325	27,997	590,322	9.00
10.00	01000	DIETARY	405,123	277,255	682,378	-534,554	147,824	10.00
11.00	01100	CAFETERIA	0	0	0	553,015	553,015	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	214,521	1,965	216,486	15,911	232,397	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	523,460	2,966,778	3,490,238	-1,794,018	1,696,220	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	2,713,092	426,968	3,140,060	-855,258	2,284,802	30.00
43.00	04300	NURSERY	0	0	0	241,537	241,537	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	923,978	418,902	1,342,880	66,476	1,409,356	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	79,779	988	80,767	888,839	969,606	52.00
53.00	05300	ANESTHESIOLOGY	0	661,623	661,623	0	661,623	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,686,216	617,617	2,303,833	93,561	2,397,394	54.00
60.00	06000	LABORATORY	0	2,574,981	2,574,981	-453	2,574,528	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	446,459	154,946	601,405	-39,096	562,309	65.00
66.00	06600	PHYSICAL THERAPY	1,224,245	336,268	1,560,513	-877,705	682,808	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	580,295	580,295	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	119,860	119,860	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	9,694	9,694	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	192	951,351	951,543	-322,907	628,636	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	322,716	322,716	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,825,520	1,825,520	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						
90.00	09000	CLINIC	90,485	18,411	108,896	16,877	125,773	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	2,541,734	2,923,957	5,465,691	158,366	5,624,057	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,413,266	261,505	1,674,771	103,413	1,778,184	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,316,892	38,614,787	54,931,679	-331,737	54,599,942	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,326	21,326	0	21,326	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,645	903,354	919,999	-1,380	918,619	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	-59,410	-59,410	59,410	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OAK POINTE	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	5	95,004	95,009	249,537	344,546	194.03
194.04	07954	COMMUNITY & VOLUNTEER SERVICES	55,201	231,149	286,350	24,170	310,520	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		TOTAL (SUM OF LINES 118-199)	16,388,743	39,806,210	56,194,953	0	56,194,953	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A | Date/Time Prepared: 3/30/2017 9:09 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	-2,096,580	1,043,421		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-45,406	1,791,900		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,224,226	3,165,803		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,120,367	14,454,887		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	-97,452	1,328,047		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	213,377		8.00
9.00	00900	HOUSEKEEPING	0	590,322		9.00
10.00	01000	DIETARY	-20,801	127,023		10.00
11.00	01100	CAFETERIA	-52,016	500,999		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	232,397		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	-927,795	768,425		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	25,083	2,309,885		30.00
43.00	04300	NURSERY	0	241,537		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,409,356		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	969,606		52.00
53.00	05300	ANESTHESIOLOGY	-643,942	17,681		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,397,394		54.00
60.00	06000	LABORATORY	0	2,574,528		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	-73,771	488,538		65.00
66.00	06600	PHYSICAL THERAPY	-324,942	357,866		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	580,295		67.00
68.00	06800	SPEECH PATHOLOGY	0	119,860		68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,694		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	628,636		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	322,716		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,825,520		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				
90.00	09000	CLINIC	0	125,773		90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0		90.01
91.00	09100	EMERGENCY	-30,576	5,593,481		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	1,778,184		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-8,632,791	45,967,151		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,326		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-318,216	600,403		192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0		194.00
194.01	07951	PAIN CLINIC	0	0		194.01
194.02	07952	OAK POINTE	0	0		194.02
194.03	07953	FOUNDATION	0	344,546		194.03
194.04	07954	COMMUNITY & VOLUNTEER SERVICES	0	310,520		194.04
194.05	07955	VACANT SPACE	0	0		194.05
200.00		TOTAL (SUM OF LINES 118-199)	-8,951,007	47,243,946		200.00

RECLASSIFICATIONS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 3/30/2017 9:09 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	311,573	218,332	1.00
	0		311,573	218,332	
	B - OB RECLASS				
1.00	NURSERY	43.00	189,197	38,307	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	691,596	140,029	2.00
	0		880,793	178,336	
	E - BUILDING AND EQUIP LEASE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	474,864	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	77,874	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
	0		0	552,738	
	G - INSURANCE RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	38,892	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	45,023	2.00
	0		0	83,915	
	H - DEPRECIATION RECLASS				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	959,696	1.00
	0		0	959,696	
	J - TAXES RECLASS				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,327	1.00
	0		0	1,327	
	K - SALARY RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	3,975,379	0	1.00
	0		3,975,379	0	
	L - REHAB THERAPY DEPT RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	517,107	33,080	1.00
2.00	SPEECH PATHOLOGY	68.00	105,314	6,735	2.00
	0		622,421	39,815	
	M - DRUGS CHARGED TO PATIENT RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,827,325	1.00
	0		0	1,827,325	
	N - PTO ACCRUAL RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	412,047	0	1.00
2.00	OPERATION OF PLANT	7.00	31,154	0	2.00
3.00	HOUSEKEEPING	9.00	28,999	0	3.00
4.00	DIETARY	10.00	6,237	0	4.00
5.00	NURSING ADMINISTRATION	13.00	15,911	0	5.00
6.00	PHARMACY	15.00	38,826	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	210,077	0	7.00
8.00	NURSERY	43.00	14,033	0	8.00
9.00	OPERATING ROOM	50.00	68,533	0	9.00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	57,214	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	125,070	0	11.00
12.00	RESPIRATORY THERAPY	65.00	33,115	0	12.00
13.00	PHYSICAL THERAPY	66.00	44,639	0	13.00
14.00	OCCUPATIONAL THERAPY	67.00	38,355	0	14.00
15.00	SPEECH PATHOLOGY	68.00	7,811	0	15.00
16.00	CLINIC	90.00	7,413	0	16.00
17.00	EMERGENCY	91.00	188,526	0	17.00
18.00	AMBULANCE SERVICES	95.00	104,825	0	18.00
19.00	PHYSICIANS' PRIVATE OFFICES	192.00	1,235	0	19.00
20.00	CAFETERIA	11.00	23,110	0	20.00
	0		1,457,130	0	
	O - CLINIC DIETICIAN RECLASS				
1.00	CLINIC	90.00	9,464	0	1.00
	0		9,464	0	

RECLASSIFICATIONS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 3/30/2017 9:09 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	P - CORPORATE DIRECT ALLOC RECLASS					
1.00	FOUNDATION	194.03	27,198	222,339		1.00
2.00	COMMUNITY & VOLUNTEER SERVICES	194.04	2,639	21,569		2.00
	0		29,837	243,908		
	Q - OCCUPATIONAL HEALTH RECLASS					
1.00	OCCUPATIONAL HEALTH	194.00	0	59,410		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	10,000		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
	0		0	69,410		
	R - IMPLANTABLE MEDICAL SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	322,716		1.00
	0		0	322,716		
	S - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	97,000		1.00
	TOTALS		0	97,000		
500.00	Grand Total: Increases		7,286,597	4,594,518		500.00

RECLASSIFICATIONS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 3/30/2017 9:09 am

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA RECLASS					
1.00	DIETARY	10.00	311,573	218,332	0	1.00
	0		311,573	218,332		
	B - OB RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	880,793	178,336	0	1.00
2.00		0.00	0	0	0	2.00
	0		880,793	178,336		
	E - BUILDING AND EQUIP LEASE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	54,122	10	1.00
2.00	OPERATION OF PLANT	7.00	0	97,158	10	2.00
3.00	RESPIRATORY THERAPY	65.00	0	69,834	0	3.00
4.00	PHYSICAL THERAPY	66.00	0	253,749	0	4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	44,372	0	5.00
6.00	OPERATION OF PLANT	7.00	0	1,235	0	6.00
7.00	HOUSEKEEPING	9.00	0	1,002	0	7.00
8.00	DIETARY	10.00	0	1,422	0	8.00
9.00	PHARMACY	15.00	0	5,519	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	0	6,206	0	10.00
11.00	OPERATING ROOM	50.00	0	1,898	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,779	0	12.00
13.00	RESPIRATORY THERAPY	65.00	0	2,363	0	13.00
14.00	PHYSICAL THERAPY	66.00	0	3,615	0	14.00
15.00	EMERGENCY	91.00	0	3,399	0	15.00
16.00	AMBULANCE SERVICES	95.00	0	1,412	0	16.00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,615	0	17.00
18.00	COMMUNITY & VOLUNTEER SERVICES	194.04	0	38	0	18.00
	0		0	552,738		
	G - INSURANCE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	83,915	12	1.00
2.00		0.00	0	0	12	2.00
	0		0	83,915		
	H - DEPRECIATION RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	959,696	9	1.00
	0		0	959,696		
	J - TAXES RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,327	13	1.00
	0		0	1,327		
	K - SALARY RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,975,379	0	1.00
	0		0	3,975,379		
	L - REHAB THERAPY DEPT RECLASS					
1.00	PHYSICAL THERAPY	66.00	622,421	39,815	0	1.00
2.00		0.00	0	0	0	2.00
	0		622,421	39,815		
	M - DRUGS CHARGED TO PATIENT RECLASS					
1.00	PHARMACY	15.00	0	1,827,325	0	1.00
	0		0	1,827,325		
	N - PTO ACCRUAL RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,457,130	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
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
19.00		0.00	0	0	0	19.00
20.00		0.00	0	0	0	20.00
	0		1,457,130	0		
	O - CLINIC DIETICIAN RECLASS					
1.00	DIETARY	10.00	9,464	0	0	1.00
	0		9,464	0		

RECLASSIFICATIONS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 3/30/2017 9:09 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	P - CORPORATE DIRECT ALLOC RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	29,837	243,908	0		1.00
2.00		0.00	0	0	0		2.00
	0		29,837	243,908			
	Q - OCCUPATIONAL HEALTH RECLASS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	28,730	0		1.00
2.00	LABORATORY	60.00	0	453	0		2.00
3.00	PHYSICAL THERAPY	66.00	0	2,744	0		3.00
4.00	OCCUPATIONAL THERAPY	67.00	0	8,247	0		4.00
5.00	ELECTROCARDIOLOGY	69.00	0	306	0		5.00
6.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	191	0		6.00
7.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,805	0		7.00
8.00	EMERGENCY	91.00	0	26,761	0		8.00
9.00	OPERATING ROOM	50.00	0	159	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	14	0		10.00
	0		0	69,410			
	R - IMPLANTABLE MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	322,716	0		1.00
	0		0	322,716			
	S - INTEREST EXPENSE						
1.00	OTHER CAP REL COSTS	3.00	0	97,000	14		1.00
	TOTALS		0	97,000			
500.00	Grand Total: Decreases		3,311,218	8,569,897			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part I Date/Time Prepared: 3/30/2017 9:09 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	260,976	0	0	0	0	1.00
2.00	Land Improvements	279,913	2,189,539	0	2,189,539	0	2.00
3.00	Buildings and Fixtures	1,119,257	13,473,808	0	13,473,808	5,000	3.00
4.00	Building Improvements	48,824	0	0	0	0	4.00
5.00	Fixed Equipment	618,063	5,645,898	0	5,645,898	0	5.00
6.00	Movable Equipment	10,783,840	4,492,587	0	4,492,587	722,813	6.00
7.00	HIT designated Assets	3,410,808	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,521,681	25,801,832	0	25,801,832	727,813	8.00
9.00	Reconciling Items	-3,314,772	1,363,894	0	1,363,894	0	9.00
10.00	Total (line 8 minus line 9)	19,836,453	24,437,938	0	24,437,938	727,813	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	260,976	0	1.00
2.00	Land Improvements	2,469,452	44,862	2.00
3.00	Buildings and Fixtures	14,588,065	237,338	3.00
4.00	Building Improvements	48,824	48,824	4.00
5.00	Fixed Equipment	6,263,961	53,545	5.00
6.00	Movable Equipment	14,553,614	5,792,193	6.00
7.00	HIT designated Assets	3,410,808	0	7.00
8.00	Subtotal (sum of lines 1-7)	41,595,700	6,176,762	8.00
9.00	Reconciling Items	-1,950,878	0	9.00
10.00	Total (line 8 minus line 9)	43,546,578	6,176,762	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part II | Date/Time Prepared: 3/30/2017 9:09 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	3,490,268	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	722,309	31,077	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,212,577	31,077	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	3,490,268	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	753,386	2.00
3.00	Total (sum of lines 1-2)	0	4,243,654	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-7 Part III Date/Time Prepared: 3/30/2017 9:09 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	26,946,049	0	26,946,049	0.651984	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,649,649	266,378	14,383,271	0.348016	0	2.00
3.00	Total (sum of lines 1-2)	41,595,698	266,378	41,329,320	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	433,992	474,864	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,636,599	108,951	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,070,591	583,815	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	38,892	-1,327	97,000	1,043,421	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	45,023	1,327	0	1,791,900	2.00
3.00	Total (sum of lines 1-2)	0	83,915	0	97,000	2,835,321	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 3/30/2017 9:09 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-294	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	-36,953			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	-4,117,379			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-18,225	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		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	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	MISCELLANEOUS REVENUE	B	-3,962	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	TELEMETRY ADJUSTMENT	A	25,083	ADULTS & PEDIATRICS	30.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8 | Date/Time Prepared: 3/30/2017 9:09 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
35.00	POSTURE ASSESSMENTS	B	-71,193	PHYSICAL THERAPY	66.00	0	35.00
36.00	ANESTHESIA PROFESSIONAL FEES	A	-637,565	ANESTHESIOLOGY	53.00	0	36.00
38.00	NON-PATIENT LAB REV.	B	-3,937	RESPIRATORY THERAPY	65.00	0	38.00
39.00	TELEVISION OFFSET	A	-45,406	CAP REL COSTS-MVBLE EQUIP	2.00	9	39.00
40.00	ANSWERING SERVICE	A	-1,897	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	PHYSICIAN RECRUITING	A	-25,000	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	MEALS ON WHEELS	A	-20,801	DIETARY	10.00	0	42.00
43.00	VISITOR MEALS	A	-33,791	CAFETERIA	11.00	0	43.00
44.00	PHARMACY SALES	A	-920,277	PHARMACY	15.00	0	44.00
45.00	COMMUNITY HEALTH & VOLUNTEER SV	A	-10,835	ADMINISTRATIVE & GENERAL	5.00	0	45.00
46.00	SELF INSURANCE	A	-2,224,226	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	46.00
48.00	LOBBY EXPENSE	A	-3,752	ADMINISTRATIVE & GENERAL	5.00	0	48.00
48.01	INTERUNIT RENT EXPENSE	A	-69,834	RESPIRATORY THERAPY	65.00	0	48.01
48.02	INTERUNIT RENT EXPENSE	A	-253,749	PHYSICAL THERAPY	66.00	0	48.02
48.03	INTERUNIT RENT EXPENSE	A	-54,122	ADMINISTRATIVE & GENERAL	5.00	0	48.03
48.04	INTERUNIT RENT EXPENSE	A	-97,158	OPERATION OF PLANT	7.00	0	48.04
49.00	OPERATING INTEREST	A	-7,518	PHARMACY	15.00	0	49.00
49.02	RENT EXPENSE - PHYSICIANS' CLINIC	A	-318,216	PHYSICIANS' PRIVATE OFFICES	192.00	0	49.02
49.07			0		0.00	0	49.07
49.10			0		0.00	0	49.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,951,007				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: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 3/30/2017 9:09 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	INTERCOMPANY RENT	0	2,096,580	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	REMOVE PPG SUBSIDY	0	4,674,018	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	11,070,219	8,417,000	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.			11,070,219	15,187,598	5.00

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

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

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

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

6.00	B		0.00	PARKVIEW HEALTH	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

(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: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-1 | Date/Time Prepared: 3/30/2017 9:09 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	-2,096,580	9		1.00
2.00	-4,674,018	0		2.00
3.00	2,653,219	0		3.00
4.00	0	0		4.00
5.00	-4,117,379			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: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A-8-2 | Date/Time Prepared: 3/30/2017 9:09 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	91.00	DR. A	60,406	0	60,406	171,400	362	1.00
2.00	53.00	DR. B	24,000	0	24,000	200,300	183	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		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			84,406	0	84,406		545	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	91.00	DR. A	29,830	1,492	0	0	0	1.00
2.00	53.00	DR. B	17,623	881	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		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			47,453	2,373	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	91.00	DR. A	0	29,830	30,576	30,576		1.00
2.00	53.00	DR. B	0	17,623	6,377	6,377		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		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	47,453	36,953	36,953		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 3/30/2017 9:09 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	1,043,421	1,043,421				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,791,900		1,791,900			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,165,803	0	0	3,165,803		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,454,887	318,584	547,109	935,757	16,256,337	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,328,047	78,103	134,129	70,754	1,611,033	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	213,377	3,649	6,267	0	223,293	8.00
9.00	00900	HOUSEKEEPING	590,322	3,050	5,238	65,861	664,471	9.00
10.00	01000	DIETARY	127,023	13,076	22,455	14,165	176,719	10.00
11.00	01100	CAFETERIA	500,999	14,745	25,323	52,485	593,552	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	232,397	889	1,526	36,137	270,949	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,557	18,131	0	28,688	14.00
15.00	01500	PHARMACY	768,425	9,150	15,714	88,178	881,467	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,252	5,585	0	8,837	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	2,309,885	142,821	245,272	320,287	3,018,265	30.00
43.00	04300	NURSERY	241,537	0	0	31,871	273,408	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,409,356	85,294	146,479	155,647	1,796,776	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	969,606	0	0	129,940	1,099,546	52.00
53.00	05300	ANESTHESIOLOGY	17,681	0	0	0	17,681	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,397,394	104,551	179,548	284,048	2,965,541	54.00
60.00	06000	LABORATORY	2,574,528	31,315	53,779	0	2,659,622	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	488,538	15,796	27,127	75,207	606,668	65.00
66.00	06600	PHYSICAL THERAPY	357,866	83,631	143,623	101,379	686,499	66.00
67.00	06700	OCCUPATIONAL THERAPY	580,295	0	0	87,108	667,403	67.00
68.00	06800	SPEECH PATHOLOGY	119,860	0	0	17,740	137,600	68.00
69.00	06900	ELECTROCARDIOLOGY	9,694	0	0	0	9,694	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	628,636	0	0	30	628,666	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	322,716	0	0	0	322,716	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,825,520	0	0	0	1,825,520	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						
90.00	09000	CLINIC	125,773	24,151	41,476	16,837	208,237	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	5,593,481	96,949	166,494	428,162	6,285,086	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,778,184	0	0	238,069	2,016,253	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	45,967,151	1,039,563	1,785,275	3,149,662	45,940,527	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,326	1,939	3,330	0	26,595	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	600,403	0	0	2,804	603,207	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OAK POINTE	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	344,546	0	0	4,266	348,812	194.03
194.04	07954	COMMUNITY & VOLUNTEER SERVICES	310,520	1,919	3,295	9,071	324,805	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	47,243,946	1,043,421	1,791,900	3,165,803	47,243,946	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 3/30/2017 9:09 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	16,256,337					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	845,161	0	2,456,194			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	117,141	0	13,859	354,293		8.00
9.00	00900	HOUSEKEEPING	348,587	0	11,584	0	1,024,642	9.00
10.00	01000	DIETARY	92,708	0	49,659	0	20,933	10.00
11.00	01100	CAFETERIA	311,382	0	56,000	0	23,606	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	142,142	0	3,375	0	1,423	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15,050	0	40,095	0	16,901	14.00
15.00	01500	PHARMACY	462,425	0	34,751	0	14,649	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,636	0	12,351	0	5,206	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	1,583,406	0	542,413	19,554	228,645	30.00
43.00	04300	NURSERY	143,432	0	0	20,706	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	942,603	0	323,933	59,199	136,549	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	576,831	0	0	75,999	0	52.00
53.00	05300	ANESTHESIOLOGY	9,276	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,555,747	0	397,066	52,335	167,376	54.00
60.00	06000	LABORATORY	1,395,259	0	118,931	310	50,133	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	318,263	0	59,989	1,974	25,288	65.00
66.00	06600	PHYSICAL THERAPY	360,143	0	317,617	11,426	133,886	66.00
67.00	06700	OCCUPATIONAL THERAPY	350,125	0	0	12,178	0	67.00
68.00	06800	SPEECH PATHOLOGY	72,186	0	0	3,160	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,086	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	329,803	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	169,299	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	957,682	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						
90.00	09000	CLINIC	109,243	0	91,723	2,759	38,664	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	3,297,195	0	368,196	79,073	155,207	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,057,742	0	0	15,620	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,572,553	0	2,441,542	354,293	1,018,466	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,952	0	7,364	0	3,104	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	316,447	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OAK POINTE	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	182,990	0	0	0	0	194.03
194.04	07954	COMMUNITY & VOLUNTEER SERVICES	170,395	0	7,288	0	3,072	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	16,256,337	0	2,456,194	354,293	1,024,642	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 3/30/2017 9:09 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	340,019					10.00
11.00	01100	CAFETERIA	0	984,540				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	14,242	0	432,131		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	100,734	14.00
15.00	01500	PHARMACY	0	26,646	0	0	5,379	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	340,019	144,258	0	130,974	1,674	30.00
43.00	04300	NURSERY	0	12,864	0	0	1,733	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	73,967	0	67,155	15,028	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	50,996	0	46,300	6,337	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	142,880	0	0	3,302	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	38,132	0	0	3,621	65.00
66.00	06600	PHYSICAL THERAPY	0	77,642	0	0	711	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	21,593	0	0	611	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,513	0	0	124	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	32,667	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	15,185	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						
90.00	09000	CLINIC	0	7,810	0	0	691	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	206,740	0	187,702	6,485	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	148,393	0	0	5,927	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	340,019	971,676	0	432,131	99,475	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	1,085	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,216	0	0	174	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OAK POINTE	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	4,594	0	0	0	194.03
194.04	07954	COMMUNITY & VOLUNTEER SERVICES	0	5,054	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	340,019	984,540	0	432,131	100,734	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 3/30/2017 9:09 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	1,425,317					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	31,030				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	5	2,554	0	0	0	30.00
43.00	04300	NURSERY	0	528	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	82	596	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	427	13,050	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	981	3,230	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,142	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	419	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	1,417,670	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						
90.00	09000	CLINIC	4	0	0	0	0	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	3,097	9,511	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,051	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,425,317	31,030	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	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OAK POINTE	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
194.04	07954	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	1,425,317	31,030	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 3/30/2017 9:09 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	6,011,767	0	30.00
43.00	04300	NURSERY	0	0	0	452,671	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	3,415,888	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,856,009	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	26,957	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,297,724	0	54.00
60.00	06000	LABORATORY	0	0	0	4,224,255	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	1,053,935	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,592,135	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,053,052	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	219,002	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,780	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	991,136	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	507,200	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,200,872	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						
90.00	09000	CLINIC	0	0	0	459,131	0	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	10,598,292	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	3,246,986	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	45,221,792	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	52,100	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	923,044	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OAK POINTE	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	536,396	0	194.03
194.04	07954	COMMUNITY & VOLUNTEER SERVICES	0	0	0	510,614	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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	47,243,946	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part I Date/Time Prepared: 3/30/2017 9:09 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	6,011,767		30.00
43.00	04300	NURSERY	452,671		43.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	3,415,888		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,856,009		52.00
53.00	05300	ANESTHESIOLOGY	26,957		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,297,724		54.00
60.00	06000	LABORATORY	4,224,255		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62.30
65.00	06500	RESPIRATORY THERAPY	1,053,935		65.00
66.00	06600	PHYSICAL THERAPY	1,592,135		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,053,052		67.00
68.00	06800	SPEECH PATHOLOGY	219,002		68.00
69.00	06900	ELECTROCARDIOLOGY	14,780		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	991,136		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	507,200		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,200,872		73.00
76.97	07697	CARDIAC REHABILITATION	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		76.98
76.99	07699	LITHOTRIPSY	0		76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	459,131		90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0		90.01
91.00	09100	EMERGENCY	10,598,292		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	3,246,986		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	45,221,792		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	52,100		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	923,044		192.00
194.00	07950	OCCUPATIONAL HEALTH	0		194.00
194.01	07951	PAIN CLINIC	0		194.01
194.02	07952	OAK POINTE	0		194.02
194.03	07953	FOUNDATION	536,396		194.03
194.04	07954	COMMUNITY & VOLUNTEER SERVICES	510,614		194.04
194.05	07955	VACANT SPACE	0		194.05
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	47,243,946		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 3/30/2017 9:09 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	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,528,279	318,584	547,109	4,393,972	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	78,103	134,129	212,232	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,649	6,267	9,916	0	8.00
9.00	00900	HOUSEKEEPING	0	3,050	5,238	8,288	0	9.00
10.00	01000	DIETARY	0	13,076	22,455	35,531	0	10.00
11.00	01100	CAFETERIA	0	14,745	25,323	40,068	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	889	1,526	2,415	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,557	18,131	28,688	0	14.00
15.00	01500	PHARMACY	0	9,150	15,714	24,864	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,252	5,585	8,837	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	142,821	245,272	388,093	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	85,294	146,479	231,773	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	104,551	179,548	284,099	0	54.00
60.00	06000	LABORATORY	0	31,315	53,779	85,094	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	15,796	27,127	42,923	0	65.00
66.00	06600	PHYSICAL THERAPY	0	83,631	143,623	227,254	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						
90.00	09000	CLINIC	0	24,151	41,476	65,627	0	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	96,949	166,494	263,443	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	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,528,279	1,039,563	1,785,275	6,353,117	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,939	3,330	5,269	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OAK POINTE	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
194.04	07954	COMMUNITY & VOLUNTEER SERVICES	0	1,919	3,295	5,214	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	3,528,279	1,043,421	1,791,900	6,363,600	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 3/30/2017 9:09 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	4,393,972					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	228,441	0	440,673			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	31,663	0	2,487	44,066		8.00
9.00	00900	HOUSEKEEPING	94,221	0	2,078	0	104,587	9.00
10.00	01000	DIETARY	25,058	0	8,909	0	2,137	10.00
11.00	01100	CAFETERIA	84,164	0	10,047	0	2,410	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	38,420	0	606	0	145	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,068	0	7,194	0	1,725	14.00
15.00	01500	PHARMACY	124,990	0	6,235	0	1,495	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,253	0	2,216	0	531	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	427,984	0	97,314	2,432	23,338	30.00
43.00	04300	NURSERY	38,769	0	0	2,575	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	254,779	0	58,118	7,363	13,938	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	155,913	0	0	9,453	0	52.00
53.00	05300	ANESTHESIOLOGY	2,507	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	420,508	0	71,239	6,509	17,084	54.00
60.00	06000	LABORATORY	377,129	0	21,338	39	5,117	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	86,024	0	10,763	246	2,581	65.00
66.00	06600	PHYSICAL THERAPY	97,344	0	56,985	1,421	13,666	66.00
67.00	06700	OCCUPATIONAL THERAPY	94,636	0	0	1,515	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,511	0	0	393	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,375	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	89,144	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,760	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	258,855	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						
90.00	09000	CLINIC	29,528	0	16,456	343	3,947	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	891,204	0	66,059	9,834	15,842	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	285,901	0	0	1,943	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,209,149	0	438,044	44,066	103,956	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,771	0	1,321	0	317	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	85,534	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OAK POINTE	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	49,461	0	0	0	0	194.03
194.04	07954	COMMUNITY & VOLUNTEER SERVICES	46,057	0	1,308	0	314	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	4,393,972	0	440,673	44,066	104,587	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 3/30/2017 9:09 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	71,635					10.00
11.00	01100	CAFETERIA	0	136,689				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	1,977	0	43,563		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	41,675	14.00
15.00	01500	PHARMACY	0	3,699	0	0	2,225	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	71,635	20,028	0	13,203	692	30.00
43.00	04300	NURSERY	0	1,786	0	0	717	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	10,269	0	6,770	6,217	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,080	0	4,667	2,622	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,837	0	0	1,366	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	5,294	0	0	1,498	65.00
66.00	06600	PHYSICAL THERAPY	0	10,779	0	0	294	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,998	0	0	253	67.00
68.00	06800	SPEECH PATHOLOGY	0	765	0	0	51	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	13,516	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6,282	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						
90.00	09000	CLINIC	0	1,084	0	0	286	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	28,705	0	18,923	2,683	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	20,602	0	0	2,452	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	71,635	134,903	0	43,563	41,154	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	449	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	446	0	0	72	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OAK POINTE	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	638	0	0	0	194.03
194.04	07954	COMMUNITY & VOLUNTEER SERVICES	0	702	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	71,635	136,689	0	43,563	41,675	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 3/30/2017 9:09 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	163,508					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,837				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	1	1,056	0			30.00
43.00	04300	NURSERY	0	218	0			43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9	246	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	49	5,401	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	112	1,336	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	472	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	173	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	162,632	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						
90.00	09000	CLINIC	0	0	0			90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0			90.01
91.00	09100	EMERGENCY	355	3,935	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	350	0	0			95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	163,508	12,837	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	OCCUPATIONAL HEALTH	0	0	0			194.00
194.01	07951	PAIN CLINIC	0	0	0			194.01
194.02	07952	OAK POINTE	0	0	0			194.02
194.03	07953	FOUNDATION	0	0	0			194.03
194.04	07954	COMMUNITY & VOLUNTEER SERVICES	0	0	0			194.04
194.05	07955	VACANT SPACE	0	0	0			194.05
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)	163,508	12,837	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 3/30/2017 9:09 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS 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				1,045,776	0	30.00
43.00	04300	NURSERY				44,065	0	43.00
44.00	04400	SKILLED NURSING FACILITY				0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM				589,482	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				179,735	0	52.00
53.00	05300	ANESTHESIOLOGY				2,507	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				826,092	0	54.00
60.00	06000	LABORATORY				488,717	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				149,329	0	65.00
66.00	06600	PHYSICAL THERAPY				409,191	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				99,874	0	67.00
68.00	06800	SPEECH PATHOLOGY				20,893	0	68.00
69.00	06900	ELECTROCARDIOLOGY				1,375	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				102,660	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				52,042	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				421,487	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						
90.00	09000	CLINIC				117,271	0	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM				0	0	90.01
91.00	09100	EMERGENCY				1,300,983	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				311,248	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	6,162,727	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				11,127	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES				86,052	0	192.00
194.00	07950	OCCUPATIONAL HEALTH				0	0	194.00
194.01	07951	PAIN CLINIC				0	0	194.01
194.02	07952	OAK POINTE				0	0	194.02
194.03	07953	FOUNDATION				50,099	0	194.03
194.04	07954	COMMUNITY & VOLUNTEER SERVICES				53,595	0	194.04
194.05	07955	VACANT SPACE				0	0	194.05
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	6,363,600	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B Part II Date/Time Prepared: 3/30/2017 9:09 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	1,045,776		30.00
43.00	04300	NURSERY	44,065		43.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	589,482		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	179,735		52.00
53.00	05300	ANESTHESIOLOGY	2,507		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	826,092		54.00
60.00	06000	LABORATORY	488,717		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62.30
65.00	06500	RESPIRATORY THERAPY	149,329		65.00
66.00	06600	PHYSICAL THERAPY	409,191		66.00
67.00	06700	OCCUPATIONAL THERAPY	99,874		67.00
68.00	06800	SPEECH PATHOLOGY	20,893		68.00
69.00	06900	ELECTROCARDIOLOGY	1,375		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	102,660		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,042		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	421,487		73.00
76.97	07697	CARDIAC REHABILITATION	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		76.98
76.99	07699	LITHOTRIPSY	0		76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	117,271		90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0		90.01
91.00	09100	EMERGENCY	1,300,983		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	311,248		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,162,727		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,127		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	86,052		192.00
194.00	07950	OCCUPATIONAL HEALTH	0		194.00
194.01	07951	PAIN CLINIC	0		194.01
194.02	07952	OAK POINTE	0		194.02
194.03	07953	FOUNDATION	50,099		194.03
194.04	07954	COMMUNITY & VOLUNTEER SERVICES	53,595		194.04
194.05	07955	VACANT SPACE	0		194.05
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	6,363,600		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 3/30/2017 9:09 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	154,970					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		154,970				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	20,187,429			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	47,316	47,316	5,967,108	-16,256,337	30,987,609	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	11,600	11,600	451,178	0	1,611,033	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	542	542	0	0	223,293	8.00
9.00	00900	HOUSEKEEPING	453	453	419,975	0	664,471	9.00
10.00	01000	DIETARY	1,942	1,942	90,323	0	176,719	10.00
11.00	01100	CAFETERIA	2,190	2,190	334,683	0	593,552	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	132	132	230,432	0	270,949	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,568	1,568	0	0	28,688	14.00
15.00	01500	PHARMACY	1,359	1,359	562,286	0	881,467	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	483	483	0	0	8,837	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	21,212	21,212	2,042,376	0	3,018,265	30.00
43.00	04300	NURSERY	0	0	203,230	0	273,408	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,668	12,668	992,511	0	1,796,776	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	828,589	0	1,099,546	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	17,681	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,528	15,528	1,811,286	0	2,965,541	54.00
60.00	06000	LABORATORY	4,651	4,651	0	0	2,659,622	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,346	2,346	479,574	0	606,668	65.00
66.00	06600	PHYSICAL THERAPY	12,421	12,421	646,463	0	686,499	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	555,462	0	667,403	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	113,125	0	137,600	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	9,694	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	192	0	628,666	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	322,716	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,825,520	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						
90.00	09000	CLINIC	3,587	3,587	107,362	0	208,237	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	14,399	14,399	2,730,260	0	6,285,086	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	1,518,091	0	2,016,253	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	154,397	154,397	20,084,506	-16,256,337	29,684,190	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	288	288	0	0	26,595	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	17,880	0	603,207	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OAK POINTE	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	27,203	0	348,812	194.03
194.04	07954	COMMUNITY & VOLUNTEER SERVICES	285	285	57,840	0	324,805	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,043,421	1,791,900	3,165,803		16,256,337	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.733052	11.562883	0.156821		0.524608	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		4,393,972	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 3/30/2017 9:09 am

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.141798	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 3/30/2017 9:09 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	96,054				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	542	226,116			8.00
9.00	00900	HOUSEKEEPING	0	453	0	95,059		9.00
10.00	01000	DIETARY	0	1,942	0	1,942	11,820	10.00
11.00	01100	CAFETERIA	0	2,190	0	2,190	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	132	0	132	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,568	0	1,568	0	14.00
15.00	01500	PHARMACY	0	1,359	0	1,359	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	483	0	483	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	21,212	12,480	21,212	11,820	30.00
43.00	04300	NURSERY	0	0	13,215	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	12,668	37,782	12,668	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	48,504	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,528	33,401	15,528	0	54.00
60.00	06000	LABORATORY	0	4,651	198	4,651	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,346	1,260	2,346	0	65.00
66.00	06600	PHYSICAL THERAPY	0	12,421	7,292	12,421	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	7,772	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	2,017	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						
90.00	09000	CLINIC	0	3,587	1,761	3,587	0	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	14,399	50,465	14,399	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	9,969	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	95,481	226,116	94,486	11,820	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	288	0	288	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OAK POINTE	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
194.04	07954	COMMUNITY & VOLUNTEER SERVICES	0	285	0	285	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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	2,456,194	354,293	1,024,642	340,019	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	25.570970	1.566864	10.779011	28.766413	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	440,673	44,066	104,587	71,635	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	4.587763	0.194882	1.100232	6.060491	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 3/30/2017 9:09 am

		Cost Center Description	CAFETERIA (FTES)	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	2,143					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	31	0	1,036			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	2,057,480		14.00
15.00	01500	PHARMACY	58	0	0	109,869	1,883,878	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	314	0	314	34,185	6	30.00
43.00	04300	NURSERY	28	0	0	35,398	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	161	0	161	306,943	109	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	111	0	111	129,436	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	311	0	0	67,451	565	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	83	0	0	73,967	0	65.00
66.00	06600	PHYSICAL THERAPY	169	0	0	14,520	1,296	66.00
67.00	06700	OCCUPATIONAL THERAPY	47	0	0	12,476	0	67.00
68.00	06800	SPEECH PATHOLOGY	12	0	0	2,540	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	667,196	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	310,160	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,873,771	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						
90.00	09000	CLINIC	17	0	0	14,119	5	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	450	0	450	132,465	4,094	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	323	0	0	121,056	4,032	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,115	0	1,036	2,031,781	1,883,878	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	22,151	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7	0	0	3,548	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OAK POINTE	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	10	0	0	0	0	194.03
194.04	07954	COMMUNITY & VOLUNTEER SERVICES	11	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	984,540	0	432,131	100,734	1,425,317	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	459.421372	0.000000	417.114865	0.048960	0.756587	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	136,689	0	43,563	41,675	163,508	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	63.783948	0.000000	42.049228	0.020255	0.086793	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 3/30/2017 9:09 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	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	10,000					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	823	0	0	0	0	30.00
43.00	04300	NURSERY	170	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	192	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	4,206	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	1,041	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	368	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	135	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						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	3,065	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	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,000	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	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OAK POINTE	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
194.04	07954	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
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)	31,030	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.103000	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,837	0	0	0	0	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 3/30/2017 9:09 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	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	
205.00		Unit cost multiplier (Wkst. B, Part II)	1.283700	0.000000	0.000000	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 3/30/2017 9:09 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
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		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				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0		90.01
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				
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	OCCUPATIONAL HEALTH	0	0		194.00
194.01	07951	PAIN CLINIC	0	0		194.01
194.02	07952	OAK POINTE	0	0		194.02
194.03	07953	FOUNDATION	0	0		194.03
194.04	07954	COMMUNITY & VOLUNTEER SERVICES	0	0		194.04
194.05	07955	VACANT SPACE	0	0		194.05
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
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet B-1 | Date/Time Prepared: 3/30/2017 9:09 am

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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 3/30/2017 9:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,011,767		6,011,767	0	6,011,767	30.00
43.00	04300	NURSERY	452,671		452,671	0	452,671	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,415,888		3,415,888	0	3,415,888	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,856,009		1,856,009	0	1,856,009	52.00
53.00	05300	ANESTHESIOLOGY	26,957		26,957	6,377	33,334	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,297,724		5,297,724	0	5,297,724	54.00
60.00	06000	LABORATORY	4,224,255		4,224,255	0	4,224,255	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,053,935	0	1,053,935	0	1,053,935	65.00
66.00	06600	PHYSICAL THERAPY	1,592,135	0	1,592,135	0	1,592,135	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,053,052	0	1,053,052	0	1,053,052	67.00
68.00	06800	SPEECH PATHOLOGY	219,002	0	219,002	0	219,002	68.00
69.00	06900	ELECTROCARDIOLOGY	14,780		14,780	0	14,780	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	991,136		991,136	0	991,136	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	507,200		507,200	0	507,200	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,200,872		4,200,872	0	4,200,872	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	459,131		459,131	0	459,131	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0		0	0	0	90.01
91.00	09100	EMERGENCY	10,598,292		10,598,292	30,576	10,628,868	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,570,319		1,570,319		1,570,319	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,246,986		3,246,986	0	3,246,986	95.00
200.00		Subtotal (see instructions)	46,792,111	0	46,792,111	36,953	46,829,064	200.00
201.00		Less Observation Beds	1,570,319		1,570,319		1,570,319	201.00
202.00		Total (see instructions)	45,221,792	0	45,221,792	36,953	45,258,745	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 3/30/2017 9:09 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	5,744,699		5,744,699			30.00
43.00	04300	NURSERY	1,674,072		1,674,072			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,697,212	18,169,799	22,867,011	0.149381	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,058,769	221,698	8,280,467	0.224143	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	449,668	2,293,080	2,742,748	0.009828	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,215,181	50,163,587	53,378,768	0.099248	0.000000	54.00
60.00	06000	LABORATORY	2,811,671	16,781,428	19,593,099	0.215599	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	899,245	3,063,087	3,962,332	0.265989	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	236,877	3,678,687	3,915,564	0.406617	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	123,721	1,025,426	1,149,147	0.916377	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	14,709	313,876	328,585	0.666500	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	828,478	2,180,849	3,009,327	0.004911	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	990,903	3,075,149	4,066,052	0.243759	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	482,139	611,060	1,093,199	0.463959	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,212,123	10,529,923	14,742,046	0.284959	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,365	205,768	207,133	2.216600	0.000000	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	2,297,110	27,356,562	29,653,672	0.357402	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,964,776	2,964,776	0.529659	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	5,096,938	5,096,938	0.637046	0.000000	95.00
200.00		Subtotal (see instructions)	36,737,942	147,731,693	184,469,635			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	36,737,942	147,731,693	184,469,635			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 3/30/2017 9:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.149381		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.224143		52.00
53.00	05300	ANESTHESIOLOGY	0.012154		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.099248		54.00
60.00	06000	LABORATORY	0.215599		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.265989		65.00
66.00	06600	PHYSICAL THERAPY	0.406617		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.916377		67.00
68.00	06800	SPEECH PATHOLOGY	0.666500		68.00
69.00	06900	ELECTROCARDIOLOGY	0.004911		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.243759		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.463959		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284959		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	2.216600		90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0.000000		90.01
91.00	09100	EMERGENCY	0.358433		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.529659		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.637046		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 3/30/2017 9:09 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,011,767		6,011,767	0	6,011,767	30.00
43.00	04300	NURSERY	452,671		452,671	0	452,671	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,415,888		3,415,888	0	3,415,888	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,856,009		1,856,009	0	1,856,009	52.00
53.00	05300	ANESTHESIOLOGY	26,957		26,957	6,377	33,334	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,297,724		5,297,724	0	5,297,724	54.00
60.00	06000	LABORATORY	4,224,255		4,224,255	0	4,224,255	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,053,935	0	1,053,935	0	1,053,935	65.00
66.00	06600	PHYSICAL THERAPY	1,592,135	0	1,592,135	0	1,592,135	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,053,052	0	1,053,052	0	1,053,052	67.00
68.00	06800	SPEECH PATHOLOGY	219,002	0	219,002	0	219,002	68.00
69.00	06900	ELECTROCARDIOLOGY	14,780		14,780	0	14,780	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	991,136		991,136	0	991,136	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	507,200		507,200	0	507,200	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,200,872		4,200,872	0	4,200,872	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	459,131		459,131	0	459,131	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0		0	0	0	90.01
91.00	09100	EMERGENCY	10,598,292		10,598,292	30,576	10,628,868	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,570,319		1,570,319		1,570,319	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,246,986		3,246,986	0	3,246,986	95.00
200.00		Subtotal (see instructions)	46,792,111	0	46,792,111	36,953	46,829,064	200.00
201.00		Less Observation Beds	1,570,319		1,570,319		1,570,319	201.00
202.00		Total (see instructions)	45,221,792	0	45,221,792	36,953	45,258,745	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 3/30/2017 9:09 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	5,744,699		5,744,699			30.00
43.00	04300	NURSERY	1,674,072		1,674,072			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,697,212	18,169,799	22,867,011	0.149381	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,058,769	221,698	8,280,467	0.224143	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	449,668	2,293,080	2,742,748	0.009828	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,215,181	50,163,587	53,378,768	0.099248	0.000000	54.00
60.00	06000	LABORATORY	2,811,671	16,781,428	19,593,099	0.215599	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	899,245	3,063,087	3,962,332	0.265989	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	236,877	3,678,687	3,915,564	0.406617	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	123,721	1,025,426	1,149,147	0.916377	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	14,709	313,876	328,585	0.666500	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	828,478	2,180,849	3,009,327	0.004911	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	990,903	3,075,149	4,066,052	0.243759	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	482,139	611,060	1,093,199	0.463959	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,212,123	10,529,923	14,742,046	0.284959	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,365	205,768	207,133	2.216600	0.000000	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	2,297,110	27,356,562	29,653,672	0.357402	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,964,776	2,964,776	0.529659	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	5,096,938	5,096,938	0.637046	0.000000	95.00
200.00		Subtotal (see instructions)	36,737,942	147,731,693	184,469,635			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	36,737,942	147,731,693	184,469,635			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 3/30/2017 9:09 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
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.149381		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.224143		52.00
53.00	05300	ANESTHESIOLOGY	0.012154		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.099248		54.00
60.00	06000	LABORATORY	0.215599		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.265989		65.00
66.00	06600	PHYSICAL THERAPY	0.406617		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.916377		67.00
68.00	06800	SPEECH PATHOLOGY	0.666500		68.00
69.00	06900	ELECTROCARDIOLOGY	0.004911		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.243759		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.463959		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284959		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	2.216600		90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0.000000		90.01
91.00	09100	EMERGENCY	0.358433		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.529659		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.637046		95.00
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: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part II Date/Time Prepared: 3/30/2017 9:09 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	3,415,888	589,482	2,826,406	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,856,009	179,735	1,676,274	0	0	52.00
53.00	05300	ANESTHESIOLOGY	26,957	2,507	24,450	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,297,724	826,092	4,471,632	0	0	54.00
60.00	06000	LABORATORY	4,224,255	488,717	3,735,538	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,053,935	149,329	904,606	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,592,135	409,191	1,182,944	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,053,052	99,874	953,178	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	219,002	20,893	198,109	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	14,780	1,375	13,405	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	991,136	102,660	888,476	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	507,200	52,042	455,158	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,200,872	421,487	3,779,385	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						
90.00	09000	CLINIC	459,131	117,271	341,860	0	0	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	10,598,292	1,300,983	9,297,309	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,570,319	273,165	1,297,154	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,246,986	311,248	2,935,738	0	0	95.00
200.00		Subtotal (sum of lines 50 thru 199)	40,327,673	5,346,051	34,981,622	0	0	200.00
201.00		Less Observation Beds	1,570,319	273,165	1,297,154	0	0	201.00
202.00		Total (line 200 minus line 201)	38,757,354	5,072,886	33,684,468	0	0	202.00

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

Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part II Date/Time Prepared: 3/30/2017 9:09 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	3,415,888	22,867,011	0.149381		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,856,009	8,280,467	0.224143		52.00
53.00	05300	ANESTHESIOLOGY	26,957	2,742,748	0.009828		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,297,724	53,378,768	0.099248		54.00
60.00	06000	LABORATORY	4,224,255	19,593,099	0.215599		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	1,053,935	3,962,332	0.265989		65.00
66.00	06600	PHYSICAL THERAPY	1,592,135	3,915,564	0.406617		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,053,052	1,149,147	0.916377		67.00
68.00	06800	SPEECH PATHOLOGY	219,002	328,585	0.666500		68.00
69.00	06900	ELECTROCARDIOLOGY	14,780	3,009,327	0.004911		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	991,136	4,066,052	0.243759		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	507,200	1,093,199	0.463959		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,200,872	14,742,046	0.284959		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000		76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000		76.99
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	459,131	207,133	2.216600		90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0.000000		90.01
91.00	09100	EMERGENCY	10,598,292	29,653,672	0.357402		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,570,319	2,964,776	0.529659		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	3,246,986	5,096,938	0.637046		95.00
200.00		Subtotal (sum of lines 50 thru 199)	40,327,673	177,050,864			200.00
201.00		Less Observation Beds	1,570,319	0			201.00
202.00		Total (line 200 minus line 201)	38,757,354	177,050,864			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part I Date/Time Prepared: 3/30/2017 9:09 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	1,045,776	0	1,045,776	5,130	203.85	30.00
43.00	NURSERY	44,065		44,065	882	49.96	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	1,089,841		1,089,841	6,012		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	1,159	236,262		30.00
43.00	NURSERY	0	0		43.00
44.00	SKILLED NURSING FACILITY	0	0		44.00
200.00	Total (lines 30-199)	1,159	236,262		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 3/30/2017 9:09 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	589,482	22,867,011	0.025779	618,960	15,956	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	179,735	8,280,467	0.021706	7,421	161	52.00
53.00	05300	ANESTHESIOLOGY	2,507	2,742,748	0.000914	74,346	68	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	826,092	53,378,768	0.015476	1,333,415	20,636	54.00
60.00	06000	LABORATORY	488,717	19,593,099	0.024943	886,666	22,116	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	149,329	3,962,332	0.037687	313,695	11,822	65.00
66.00	06600	PHYSICAL THERAPY	409,191	3,915,564	0.104504	107,360	11,220	66.00
67.00	06700	OCCUPATIONAL THERAPY	99,874	1,149,147	0.086911	59,582	5,178	67.00
68.00	06800	SPEECH PATHOLOGY	20,893	328,585	0.063585	6,764	430	68.00
69.00	06900	ELECTROCARDIOLOGY	1,375	3,009,327	0.000457	252,102	115	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	102,660	4,066,052	0.025248	176,080	4,446	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,042	1,093,199	0.047605	180,227	8,580	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	421,487	14,742,046	0.028591	1,057,712	30,241	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	117,271	207,133	0.566163	670	379	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	1,300,983	29,653,672	0.043873	889,387	39,020	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	273,165	2,964,776	0.092137	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	5,034,803	171,953,926		5,964,387	170,368	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 3/30/2017 9:09 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
44.00	04400	SKILLED NURSING FACILITY	0	0			0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,130	0.00	1,159	0		30.00
43.00	04300	NURSERY	882	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	6,012		1,159	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 3/30/2017 9:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	90.01
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: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 3/30/2017 9:09 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	22,867,011	0.000000	0.000000	618,960	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,280,467	0.000000	0.000000	7,421	52.00
53.00	05300	ANESTHESIOLOGY	0	2,742,748	0.000000	0.000000	74,346	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	53,378,768	0.000000	0.000000	1,333,415	54.00
60.00	06000	LABORATORY	0	19,593,099	0.000000	0.000000	886,666	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	3,962,332	0.000000	0.000000	313,695	65.00
66.00	06600	PHYSICAL THERAPY	0	3,915,564	0.000000	0.000000	107,360	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,149,147	0.000000	0.000000	59,582	67.00
68.00	06800	SPEECH PATHOLOGY	0	328,585	0.000000	0.000000	6,764	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,009,327	0.000000	0.000000	252,102	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,066,052	0.000000	0.000000	176,080	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,093,199	0.000000	0.000000	180,227	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,742,046	0.000000	0.000000	1,057,712	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	207,133	0.000000	0.000000	670	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	29,653,672	0.000000	0.000000	889,387	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,964,776	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	171,953,926			5,964,387	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 3/30/2017 9:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,560,349	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	313,683	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,077,990	0		54.00
60.00	06000	LABORATORY	0	182,381	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	499,658	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	617,554	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	281,256	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	114,672	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,442,261	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					
90.00	09000	CLINIC	0	138,121	0		90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0		90.01
91.00	09100	EMERGENCY	0	4,095,153	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	482,632	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	20,805,710	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 3/30/2017 9:09 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	0.149381	2,560,349	0	0	382,467	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.224143	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.009828	313,683	0	0	3,083	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.099248	8,077,990	0	0	801,724	54.00
60.00	06000	LABORATORY	0.215599	182,381	0	0	39,321	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.265989	499,658	0	0	132,904	65.00
66.00	06600	PHYSICAL THERAPY	0.406617	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.916377	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.666500	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.004911	617,554	0	0	3,033	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.243759	281,256	0	0	68,559	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.463959	114,672	0	0	53,203	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284959	3,442,261	0	0	980,903	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.216600	138,121	0	0	306,159	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.357402	4,095,153	0	0	1,463,616	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.529659	482,632	0	0	255,630	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.637046		0			95.00
200.00		Subtotal (see instructions)		20,805,710	0	0	4,490,602	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		20,805,710	0	0	4,490,602	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 3/30/2017 9:09 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				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0		90.01
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: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part I Date/Time Prepared: 3/30/2017 9:09 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	1,045,776	0	1,045,776	5,130	203.85	30.00
43.00	NURSERY	44,065		44,065	882	49.96	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	1,089,841		1,089,841	6,012		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	132	26,908		30.00
43.00	NURSERY	123	6,145		43.00
44.00	SKILLED NURSING FACILITY	0	0		44.00
200.00	Total (lines 30-199)	255	33,053		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Prepared: 3/30/2017 9:09 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	589,482	22,867,011	0.025779	1,549,075	39,934	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	179,735	8,280,467	0.021706	1,486,797	32,272	52.00
53.00	05300	ANESTHESIOLOGY	2,507	2,742,748	0.000914	212,429	194	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	826,092	53,378,768	0.015476	368,435	5,702	54.00
60.00	06000	LABORATORY	488,717	19,593,099	0.024943	590,023	14,717	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	149,329	3,962,332	0.037687	135,808	5,118	65.00
66.00	06600	PHYSICAL THERAPY	409,191	3,915,564	0.104504	9,403	983	66.00
67.00	06700	OCCUPATIONAL THERAPY	99,874	1,149,147	0.086911	2,281	198	67.00
68.00	06800	SPEECH PATHOLOGY	20,893	328,585	0.063585	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,375	3,009,327	0.000457	81,176	37	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	102,660	4,066,052	0.025248	238,721	6,027	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,042	1,093,199	0.047605	10,265	489	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	421,487	14,742,046	0.028591	809,217	23,136	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	117,271	207,133	0.566163	337	191	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	1,300,983	29,653,672	0.043873	248,120	10,886	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	273,165	2,964,776	0.092137	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	5,034,803	171,953,926		5,742,087	139,884	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part III Date/Time Prepared: 3/30/2017 9:09 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
44.00	04400	SKILLED NURSING FACILITY	0	0			0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,130	0.00	132	0		30.00
43.00	04300	NURSERY	882	0.00	123	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	6,012		255	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV | Date/Time Prepared: 3/30/2017 9:09 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						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0	0	0	90.01
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: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 3/30/2017 9:09 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	22,867,011	0.000000	0.000000	1,549,075	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,280,467	0.000000	0.000000	1,486,797	52.00
53.00	05300	ANESTHESIOLOGY	0	2,742,748	0.000000	0.000000	212,429	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	53,378,768	0.000000	0.000000	368,435	54.00
60.00	06000	LABORATORY	0	19,593,099	0.000000	0.000000	590,023	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	3,962,332	0.000000	0.000000	135,808	65.00
66.00	06600	PHYSICAL THERAPY	0	3,915,564	0.000000	0.000000	9,403	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,149,147	0.000000	0.000000	2,281	67.00
68.00	06800	SPEECH PATHOLOGY	0	328,585	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,009,327	0.000000	0.000000	81,176	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,066,052	0.000000	0.000000	238,721	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,093,199	0.000000	0.000000	10,265	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,742,046	0.000000	0.000000	809,217	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	207,133	0.000000	0.000000	337	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	29,653,672	0.000000	0.000000	248,120	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,964,776	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	171,953,926			5,742,087	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part IV Date/Time Prepared: 3/30/2017 9:09 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					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0	0		90.01
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: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 3/30/2017 9:09 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	0.149381	0	0	3,712,538	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.224143	0	0	3,645	0	52.00
53.00	05300	ANESTHESIOLOGY	0.009828	0	0	425,524	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.099248	0	0	5,661,470	0	54.00
60.00	06000	LABORATORY	0.215599	0	0	1,861,469	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.265989	0	0	394,233	0	65.00
66.00	06600	PHYSICAL THERAPY	0.406617	0	0	462,643	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.916377	0	0	142,663	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.666500	0	0	196,819	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.004911	0	0	404,398	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.243759	0	0	514,092	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.463959	0	0	377,688	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284959	0	0	1,221,997	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.216600	0	0	18,587	0	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.357402	0	0	4,993,601	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.529659	0	0	528,567	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.637046	0	716,991			95.00
200.00		Subtotal (see instructions)		0	716,991	20,919,934	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	716,991	20,919,934	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Prepared: 3/30/2017 9:09 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	554,583		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	817		52.00
53.00	05300	ANESTHESIOLOGY	0	4,182		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	561,890		54.00
60.00	06000	LABORATORY	0	401,331		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	104,862		65.00
66.00	06600	PHYSICAL THERAPY	0	188,119		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	130,733		67.00
68.00	06800	SPEECH PATHOLOGY	0	131,180		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,986		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	125,315		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	175,232		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	348,219		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				
90.00	09000	CLINIC	0	41,200		90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0	0		90.01
91.00	09100	EMERGENCY	0	1,784,723		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	279,960		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	456,756			95.00
200.00		Subtotal (see instructions)	456,756	4,834,332		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	456,756	4,834,332		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 3/30/2017 9:09 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)	5,130	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,130	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)	3,790	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)	1,159	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)	6,011,767	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)	6,011,767	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)	6,011,767	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)	1,171.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,358,209	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)	1,358,209	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 3/30/2017 9:09 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)	1,354,185	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,712,394	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)	236,262	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	170,368	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	406,630	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,305,764	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)	1,340	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,171.88	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,570,319	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 3/30/2017 9:09 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,045,776	6,011,767	0.173955	1,570,319	273,165	90.00
91.00	Nursing School cost	0	6,011,767	0.000000	1,570,319	0	91.00
92.00	Allied health cost	0	6,011,767	0.000000	1,570,319	0	92.00
93.00	All other Medical Education	0	6,011,767	0.000000	1,570,319	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 3/30/2017 9:09 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)	5,130	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,130	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)	3,790	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)	132	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)	882	15.00
16.00	Nursery days (title V or XIX only)	123	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)	6,011,767	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)	6,011,767	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)	6,011,767	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)	1,171.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	154,688	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)	154,688	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 3/30/2017 9:09 am

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	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)	452,671	882	513.23	123	63,127	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)	1,156,676	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,374,491	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)	33,053	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	139,884	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	172,937	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,201,554	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)	1,340	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,171.88	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,570,319	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-1 | Date/Time Prepared: 3/30/2017 9:09 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	1,045,776	6,011,767	0.173955	1,570,319	273,165	90.00
91.00	Nursing School cost	0	6,011,767	0.000000	1,570,319	0	91.00
92.00	Allied health cost	0	6,011,767	0.000000	1,570,319	0	92.00
93.00	All other Medical Education	0	6,011,767	0.000000	1,570,319	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 3/30/2017 9:09 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,632,018		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.149381	618,960	92,461	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.224143	7,421	1,663	52.00
53.00	05300	ANESTHESIOLOGY	0.012154	74,346	904	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.099248	1,333,415	132,339	54.00
60.00	06000	LABORATORY	0.215599	886,666	191,164	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.265989	313,695	83,439	65.00
66.00	06600	PHYSICAL THERAPY	0.406617	107,360	43,654	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.916377	59,582	54,600	67.00
68.00	06800	SPEECH PATHOLOGY	0.666500	6,764	4,508	68.00
69.00	06900	ELECTROCARDIOLOGY	0.004911	252,102	1,238	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.243759	176,080	42,921	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.463959	180,227	83,618	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284959	1,057,712	301,405	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.216600	670	1,485	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.358433	889,387	318,786	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.529659	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)		5,964,387	1,354,185	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)		5,964,387		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D-3 | Date/Time Prepared: 3/30/2017 9:09 am

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		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,156,775		30.00
43.00	04300	NURSERY		561,168		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.149381	1,549,075	231,402	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.224143	1,486,797	333,255	52.00
53.00	05300	ANESTHESIOLOGY	0.012154	212,429	2,582	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.099248	368,435	36,566	54.00
60.00	06000	LABORATORY	0.215599	590,023	127,208	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.265989	135,808	36,123	65.00
66.00	06600	PHYSICAL THERAPY	0.406617	9,403	3,823	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.916377	2,281	2,090	67.00
68.00	06800	SPEECH PATHOLOGY	0.666500	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.004911	81,176	399	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.243759	238,721	58,190	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.463959	10,265	4,763	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284959	809,217	230,594	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.216600	337	747	90.00
90.01	09001	INTENSIVE OUT PATIENT PROGRAM	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.358433	248,120	88,934	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.529659	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)		5,742,087	1,156,676	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)		5,742,087		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0101	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 3/30/2017 9:09 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,288,531	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	447,758	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	17,680	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	26.34	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.22	30.00
31.00	Percentage of Medicaid patient days (see instructions)	32.03	31.00
32.00	Sum of lines 30 and 31	34.25	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00
34.00	Disproportionate share adjustment (see instructions)	52,089	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Date/Time Prepared: 3/30/2017 9:09 am

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		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)	0.000030771	0.000028279	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	197,121	169,037	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	147,571	42,607	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	190,178		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	1,996,236		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	1,996,236	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	147,347	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)	2,143,583	59.00
60.00	Primary payer payments	7,188	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	2,136,395	61.00
62.00	Deductibles billed to program beneficiaries	445,120	62.00
63.00	Coinsurance billed to program beneficiaries	983	63.00
64.00	Allowable bad debts (see instructions)	31,804	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	20,673	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	18,451	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	1,710,965	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)	17,032	70.93
70.94	HRR adjustment amount (see instructions)	-3,410	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Date/Time Prepared: 3/30/2017 9:09 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	284,312	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	91,124	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		18,835	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		2,081,188	71.00
71.01	Sequestration adjustment (see instructions)		41,624	71.01
72.00	Interim payments		2,109,948	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)		-70,384	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		197,717	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 3/30/2017 9:09 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	1,288,531	0	1,288,531		1,288,531	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	447,758	0		447,758	447,758	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	17,680	0	15,985	1,695	17,680	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	52,089	0	38,656	13,433	52,089	11.00
11.01	Uncompensated care payments	36.00	190,178	0	147,571	42,607	190,178	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	1,996,236	0	1,490,743	505,493	1,996,236	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	1,996,236	0	1,490,743	505,493	1,996,236	15.00
16.00	Payment for inpatient program capital	50.00	147,347	0	109,399	37,948	147,347	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	55.00	0	0	0	0	0	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: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 3/30/2017 9:09 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	1,600,142	543,441	2,143,583	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	138,667	0	102,379	36,288	138,667	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	8,680	0	7,020	1,660	8,680	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	147,347	0	109,399	37,948	147,347	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				0.177679	0.167679		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			284,312		284,312	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				91,124	91,124	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0101	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 3/30/2017 9:09 am
	Title XVIII	Hospital	PPS

		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)	4,490,602	2.00
3.00	PPS payments	3,219,605	3.00
4.00	Outlier payment (see instructions)	15,327	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	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)	3,234,932	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	713,972	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,520,960	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,520,960	30.00
31.00	Primary payer payments	886	31.00
32.00	Subtotal (line 30 minus line 31)	2,520,074	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)	104,093	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	67,660	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	78,478	36.00
37.00	Subtotal (see instructions)	2,587,734	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,587,734	40.00
40.01	Sequestration adjustment (see instructions)	51,755	40.01
41.00	Interim payments	2,454,665	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	81,314	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: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-1 Part I | Date/Time Prepared: 3/30/2017 9:09 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		2,109,948		2,454,665	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,109,948		2,454,665	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		81,314	6.01
6.02	SETTLEMENT TO PROGRAM		70,384		0	6.02
7.00	Total Medicare program liability (see instructions)		2,039,564		2,535,979	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: 15-0101	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 3/30/2017 9:09 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1,574	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,159	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,037	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	3,790	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	184,469,635	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	2,076,642	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: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G | Date/Time Prepared: 3/30/2017 9:09 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	297,432	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	22,564,679	0	0	0	4.00
5.00	Other receivable	162,454	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-15,037,947	0	0	0	6.00
7.00	Inventory	343,813	0	0	0	7.00
8.00	Prepaid expenses	38,166	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)	8,368,597	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	260,483	0	0	0	12.00
13.00	Land improvements	2,469,451	0	0	0	13.00
14.00	Accumulated depreciation	-230,087	0	0	0	14.00
15.00	Buildings	14,588,065	0	0	0	15.00
16.00	Accumulated depreciation	-971,033	0	0	0	16.00
17.00	Leasehold improvements	48,824	0	0	0	17.00
18.00	Accumulated depreciation	-48,824	0	0	0	18.00
19.00	Fixed equipment	6,263,961	0	0	0	19.00
20.00	Accumulated depreciation	-770,303	0	0	0	20.00
21.00	Automobiles and trucks	446,861	0	0	0	21.00
22.00	Accumulated depreciation	-263,787	0	0	0	22.00
23.00	Major movable equipment	15,450,609	0	0	0	23.00
24.00	Accumulated depreciation	-8,544,463	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	28,699,757	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	49,036,400	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	49,036,400	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	86,104,754	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,967,159	0	0	0	37.00
38.00	Salaries, wages, and fees payable	967,668	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	58,485	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,993,312	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	9,887,279	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-8,633,476	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,253,803	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,247,115	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	81,857,639				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)	81,857,639	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	86,104,754	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-1 | Date/Time Prepared: 3/30/2017 9:09 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		30,076,825		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		10,947,964				2.00
3.00	Total (sum of line 1 and line 2)		41,024,789		0		3.00
4.00	CREDIT ADJUSTMENTS	40,832,850		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)		40,832,850		0		10.00
11.00	Subtotal (line 3 plus line 10)		81,857,639		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		81,857,639		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	CREDIT ADJUSTMENTS		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0101 | Period: From 01/01/2016 To 12/31/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 3/30/2017 9:09 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,639,177		7,639,177	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	0		0	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)	7,639,177		7,639,177	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)	7,639,177		7,639,177	17.00
18.00	Ancillary services	25,845,914	155,146,066	180,991,980	18.00
19.00	Outpatient services	0	0	0	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	0	0	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)	33,485,091	155,146,066	188,631,157	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		56,194,953		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		56,194,953		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0101	Period: From 01/01/2016 To 12/31/2016	Worksheet G-3 Date/Time Prepared: 3/30/2017 9:09 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	188,631,157	1.00
2.00	Less contractual allowances and discounts on patients' accounts	126,979,445	2.00
3.00	Net patient revenues (line 1 minus line 2)	61,651,712	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	56,194,953	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,456,759	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	882,927	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	181,064	14.00
15.00	Revenue from rental of living quarters	4,835	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	936,962	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	29,536	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	561,172	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.01	GAIN ON DISPOSAL OF ASSETS	37,655	24.01
24.02	COUNTY REIMBURSEMENT OF AMBULANCE SE	340,000	24.02
24.03	REVENUE FROM SALE OF SCRAP	0	24.03
24.04	MISCELLANEOUS	470,702	24.04
25.00	Total other income (sum of lines 6-24)	3,444,853	25.00
26.00	Total (line 5 plus line 25)	8,901,612	26.00
27.00	UNREALIZED GAIN(LOSS)	-2,046,352	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-2,046,352	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	10,947,964	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0101	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 3/30/2017 9:09 am
	Title XVIII	Hospital	PPS

			1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	138,667	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	8,680	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)	10.97	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)	147,347	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