

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: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/30/2017 10:51 am
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<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/30/2017	Time: 10:51 am
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 COMMUNITY HOSPITAL SOUTH ( 15-0128 ) 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 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	69,303	36,167	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	69,303	36,167	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0128			Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 10:50 am				
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1402 EAST COUNTY LINE ROAD SOUTH			PO Box:						1.00	
2.00	City: INDIANAPOLIS			State: IN		Zip Code: 46227		County: MARION		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
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		COMMUNITY HOSPITAL SOUTH	150128	26900	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 days	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.			936	299	0	48	6,520	28	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: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 10:50 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)					37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.00	
		V	XVII	XIX			
		1.00	2.00	3.00			
<b>Prospective Payment System (PPS)-Capital</b>							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)	N	Y	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	
<b>Teaching Hospitals</b>							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y				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)							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			
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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		
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings 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					
64.00	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. 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

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		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	1.41	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)	FAMILY MEDICINE	1350	0.00	0.00	0.000000 67.00	
				1.00	2.00	3.00	
<b>Inpatient Psychiatric Facility PPS</b>							
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
<b>Inpatient Rehabilitation Facility PPS</b>							
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	
<b>Long Term Care Hospital PPS</b>							
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
<b>TEFRA Providers</b>							
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		
<b>Title V and XIX Services</b>							
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	
<b>Rural Providers</b>							
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. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.					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		Speech		Respiratory	
		1.00		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.					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			
<b>Miscellaneous Cost Reporting Information</b>							
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:	589,337		0		0	
				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	
<b>Transplant Center Information</b>							
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: 15-0128		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 10:50 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				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: COMMUNITY HEALTH NETWORK	Contractor's Name: WISCONSIN PHYSICIANS SERVICES		Contractor's Number: 08101		141.00	
142.00	Street: 1500 NORTH RITTER AVENUE	PO Box:				142.00	
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46219-3095		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y				144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165.00	
		Name		County		State	
		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	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					9.99	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 10:50 am
		Beginning 1.00	Ending 2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2015	12/31/2015	170.00
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. 1, 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		0171.00



HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0128		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 10:50 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				
		1.00	2.00				
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				
		1.00	2.00				
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.	Y					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/29/2014	Y	04/29/2014		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 10:50 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
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			Y	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			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
					Y/N
					Date
					1.00
					2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
					1.00
					2.00
<b>Cost Report Preparer Contact Information</b>					
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.	RONALD		HELMS	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH NETWORK			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-355-5501		RHELMS@COMMUNITY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 10:50 am
		3.00		
<b>Cost Report Preparer Contact Information</b>				
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.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2017 10:50 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				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	158	57,828	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)		158	57,828	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,392	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		170	62,220	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		170				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: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2017 10:50 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	12,526	702	30,752			1.00
2.00 HMO and other (see instructions)	4,899	5,401				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)	12,526	702	30,752			7.00
8.00 INTENSIVE CARE UNIT	1,011	0	2,464			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		1,700	4,973			13.00
14.00 Total (see instructions)	13,537	2,402	38,189	6.56	826.44	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	301			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)				6.56	826.44	27.00
28.00 Observation Bed Days		0	4,537			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			496			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	28	633			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: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2017 10:50 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	3,362	132	9,545	1.00
2.00 HMO and other (see instructions)			1,148	1,378		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	3,362	132	9,545	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/30/2017 10:50 am

	Worksheet A Line Number	Amount Reported	Reclassifi- cation 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	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	54,985,518	-455,558	54,529,960	1,718,988.00	31.72
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		236,654	0	236,654	1,893.00	125.02
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		643,122	0	643,122	9,609.00	66.93
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		375,018	-45	374,973	9,640.00	38.90
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract Labor: Direct Patient Care		1,237,309	0	1,237,309	17,250.00	71.73
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		1,565,904	0	1,565,904	17,155.00	91.28
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		15,226,045	0	15,226,045	394,300.00	38.62
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		30,814,534	0	30,814,534		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		180,074	0	180,074		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		37,912	0	37,912		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		140,292	0	140,292		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related		3,222,118	0	3,222,118		
25.51	Related organization wage-related		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	4.00	179,760	0	179,760	3,981.00	45.15
27.00	Administrative & General	5.00	3,745,392	-61,153	3,684,239	92,930.00	39.65

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/30/2017 10:50 am

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on 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.)		4,780,083	0	4,780,083	45,821.00	104.32	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	64,356.00	0.00	29.00
30.00	Operation of Plant	7.00	1,297,060	-3,228	1,293,832	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,245,538	-6,483	1,239,055	88,225.00	14.04	32.00
33.00	Housekeeping under contract (see instructions)		317,417	0	317,417	6,476.00	49.01	33.00
34.00	Dietary	10.00	1,159,342	-783,751	375,591	22,988.00	16.34	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	777,909	777,909	46,883.00	16.59	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	248,291	0	248,291	17,106.00	14.51	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	209,095	-1,628	207,467	5,471.00	37.92	41.00
42.00	Social Service	17.00	1,388,839	-12,279	1,376,560	38,831.00	35.45	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00



HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/30/2017 10:50 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on 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	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	59,439,896	-455,558	58,984,338	1,761,676.00	33.48	1.00
2.00	Excluded area salaries (see instructions)	375,018	-45	374,973	9,640.00	38.90	2.00
3.00	Subtotal salaries (line 1 minus line 2)	59,064,878	-455,513	58,609,365	1,752,036.00	33.45	3.00
4.00	Subtotal other wages & related costs (see inst.)	18,029,258	0	18,029,258	428,705.00	42.06	4.00
5.00	Subtotal wage-related costs (see inst.)	34,074,564	0	34,074,564	0.00	58.14	5.00
6.00	Total (sum of lines 3 thru 5)	111,168,700	-455,513	110,713,187	2,180,741.00	50.77	6.00
7.00	Total overhead cost (see instructions)	14,570,817	-90,613	14,480,204	433,068.00	33.44	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part IV Date/Time Prepared: 5/30/2017 10:50 am
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		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	1,401,887	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	17,302,176	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	5,442,240	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	2,070,334	9.00
10.00	Dental, Hearing and Vision Plan	89,943	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	27,574	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)	648,247	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	104,223	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
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	4,047,485	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
<b>OTHER</b>			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	38,705	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	31,172,814	24.00
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part V Date/Time Prepared: 5/30/2017 10:50 am
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost		1,237,309	31,172,814
2.00	Hospital		1,237,309	30,992,740
3.00	Subprovider - IPF			
4.00	Subprovider - IRF			
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	Hospital-Based SNF			
9.00	Hospital-Based NF			
10.00	Hospital-Based OLTC			
11.00	Hospital-Based HHA			
12.00	Separately Certified ASC			
13.00	Hospital-Based Hospice			
14.00	Hospital-Based Health Clinic RHC			
15.00	Hospital-Based Health Clinic FQHC			
16.00	Hospital-Based-CMHC			
17.00	Renal Dialysis		0	0
18.00	Other		0	180,074

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet S-10 Date/Time Prepared: 5/30/2017 10:50 am	
			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.243422	1.00
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid			14,707,908	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			118,742,634	6.00
7.00	Medicaid cost (line 1 times line 6)			28,904,569	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)			14,196,661	8.00
<b>Children's Health Insurance Program (CHIP) (see instructions for each line)</b>					
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
<b>Other state or local government indigent care program (see instructions for each line)</b>					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
<b>Uncompensated care (see instructions for each line)</b>					
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)			14,196,661	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)	483,137	778,850	1,261,987	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	117,606	189,589	307,195	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	117,606	189,589	307,195	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)			15,688,498	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			288,105	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			15,400,393	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			3,748,794	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			4,055,989	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			18,252,650	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet A  
Date/Time Prepared:  
5/30/2017 10:50 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		0	0	9,716,113	9,716,113	1.00
2.00	00200		0	0	6,609,584	6,609,584	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	179,760	63,600	243,360	-4,073	239,287	4.00
5.00	00500	3,745,392	77,086,318	80,831,710	-9,004,588	71,827,122	5.00
7.00	00700	1,297,060	2,256,903	3,553,963	-52,812	3,501,151	7.00
8.00	00800	0	586,684	586,684	0	586,684	8.00
9.00	00900	1,245,538	925,410	2,170,948	-25,963	2,144,985	9.00
10.00	01000	1,159,342	823,343	1,982,685	-1,355,037	627,648	10.00
11.00	01100	0	0	0	1,280,046	1,280,046	11.00
13.00	01300	248,291	52,223	300,514	0	300,514	13.00
16.00	01600	209,095	91,662	300,757	-328	300,429	16.00
17.00	01700	1,388,839	447,852	1,836,691	-2,329	1,834,362	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	19,490,600	14,770,107	34,260,707	-6,791,539	27,469,168	30.00
31.00	03100	2,193,746	1,220,444	3,414,190	-360,079	3,054,111	31.00
43.00	04300	0	0	0	3,268,528	3,268,528	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	2,817,652	18,330,000	21,147,652	-12,292,126	8,855,526	50.00
51.00	05100	2,489,896	1,155,073	3,644,969	-92,258	3,552,711	51.00
52.00	05200	401,735	113,959	515,694	2,419,708	2,935,402	52.00
54.00	05400	1,697,565	1,830,633	3,528,198	-1,000,405	2,527,793	54.00
55.00	05500	556,817	1,223,319	1,780,136	-761,884	1,018,252	55.00
57.00	05700	521,296	1,010,656	1,531,952	-289,497	1,242,455	57.00
58.00	05800	201,919	579,593	781,512	-243,759	537,753	58.00
59.00	05900	1,115,482	5,997,064	7,112,546	-4,482,852	2,629,694	59.00
60.00	06000	0	5,867,820	5,867,820	-2,259	5,865,561	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	1,604,267	1,034,106	2,638,373	-238,803	2,399,570	65.00
66.00	06600	1,853,073	1,034,685	2,887,758	-1,141,396	1,746,362	66.00
67.00	06700	0	0	0	566,233	566,233	67.00
68.00	06800	0	0	0	135,170	135,170	68.00
69.00	06900	742,768	402,517	1,145,285	-81,976	1,063,309	69.00
70.00	07000	417,107	427,278	844,385	-129,690	714,695	70.00
71.00	07100	0	763,900	763,900	5,991,388	6,755,288	71.00
72.00	07200	0	0	0	9,461,600	9,461,600	72.00
73.00	07300	2,492,597	7,511,734	10,004,331	292,326	10,296,657	73.00
74.00	07400	738	372,456	373,194	-2,298	370,896	74.00
76.00	03950	550,191	1,060,189	1,610,380	-482,524	1,127,856	76.00
76.06	03330	695,690	1,336,096	2,031,786	-583,747	1,448,039	76.06
76.97	07697	189,002	63,390	252,392	-3,893	248,499	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
90.01	04950	0	0	0	0	0	90.01
90.02	04951	510,277	165,386	675,663	-16,920	658,743	90.02
90.03	04952	0	0	0	0	0	90.03
90.04	04953	121,090	41,838	162,928	-36	162,892	90.04
91.00	09100	4,473,675	3,321,726	7,795,401	-204,013	7,591,388	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		54,610,500	151,967,964	206,578,464	93,612	206,672,076	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	202,801	488,365	691,166	-65,531	625,635	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.06	07956	0	0	0	0	0	194.06
194.08	07958	172,217	110,858	283,075	-28,081	254,994	194.08
200.00		54,985,518	152,567,187	207,552,705	0	207,552,705	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet A  
Date/Time Prepared:  
5/30/2017 10:50 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,410,571	8,305,542	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,117,941	8,727,525	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,381,520	2,620,807	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-21,565,657	50,261,465	5.00
7.00	00700	OPERATION OF PLANT	498,793	3,999,944	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	586,684	8.00
9.00	00900	HOUSEKEEPING	0	2,144,985	9.00
10.00	01000	DIETARY	-18,768	608,880	10.00
11.00	01100	CAFETERIA	-91,815	1,188,231	11.00
13.00	01300	NURSING ADMINISTRATION	1,498,380	1,798,894	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,796,180	2,096,609	16.00
17.00	01700	SOCIAL SERVICE	0	1,834,362	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	495,162	495,162	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	865,590	865,590	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	676,442	28,145,610	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,054,111	31.00
43.00	04300	NURSERY	0	3,268,528	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	8,855,526	50.00
51.00	05100	RECOVERY ROOM	0	3,552,711	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-291,650	2,643,752	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-36,520	2,491,273	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,018,252	55.00
57.00	05700	CT SCAN	0	1,242,455	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	537,753	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,629,694	59.00
60.00	06000	LABORATORY	-802,640	5,062,921	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,399,570	65.00
66.00	06600	PHYSICAL THERAPY	-69,106	1,677,256	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	566,233	67.00
68.00	06800	SPEECH PATHOLOGY	0	135,170	68.00
69.00	06900	ELECTROCARDIOLOGY	72,498	1,135,807	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	100,889	815,584	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	676,479	7,431,767	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,461,600	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	538,220	10,834,877	73.00
74.00	07400	RENAL DIALYSIS	0	370,896	74.00
76.00	03950	ENDOSCOPY	0	1,127,856	76.00
76.06	03330	IMAGING CENTER	0	1,448,039	76.06
76.97	07697	CARDIAC REHABILITATION	0	248,499	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	-224,064	434,679	90.02
90.03	04952	PALLIATIVE CARE	0	0	90.03
90.04	04953	SPINE CENTER	0	162,892	90.04
91.00	09100	EMERGENCY	0	7,591,388	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-12,792,697	193,879,379	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	625,635	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	HOME OFFICE	0	0	194.00
194.06	07956	LEASED OFFICE SPACE	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	0	254,994	194.08
200.00		TOTAL (SUM OF LINES 118-199)	-12,792,697	194,760,008	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
<b>A - Other Capital Rental Expense</b>						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,106,178	1.00	
2.00	EMERGENCY	91.00	0	4,491	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	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
0			0	2,110,669		
<b>B - Drugs Charges to Pat</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	212	1.00	
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	659,939	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	
19.00		0.00	0	0	19.00	
0			0	660,151		
<b>C - Cafeteria Salary</b>						
1.00	CAFETERIA	11.00	777,909	0	1.00	
			777,909	0		
<b>D - Cafeteria Other</b>						
1.00	CAFETERIA	11.00	0	502,137	1.00	
			0	502,137		
<b>E - Therapy Salary</b>						
1.00	OCCUPATIONAL THERAPY	67.00	0	428,513	1.00	
2.00	SPEECH PATHOLOGY	68.00	0	102,294	2.00	
0			0	530,807		
<b>F - Therapy Other</b>						
1.00	OCCUPATIONAL THERAPY	67.00	0	137,720	1.00	
2.00	SPEECH PATHOLOGY	68.00	0	32,876	2.00	
0			0	170,596		
<b>J - Implantable Device Reclass</b>						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	9,461,600	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	

RECLASSIFICATIONS

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
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	9,461,600	
<b>K - Medical Supplies</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,900,049	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	TOTALS		0	6,900,049	
<b>L - Depreciation Expense</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,797,624	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
	0		0	9,797,624	
<b>M - Interest Expense</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,271,713	1.00
	0		0	4,271,713	
<b>N - Depreciation by CC</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,294,218	1.00
	0		0	5,294,218	
<b>O - Capital Insurance Costs</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	150,182	1.00
	0		0	150,182	
<b>P - Labor and Delivery Salary</b>					
1.00	NURSERY	43.00	2,404,974	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,780,415	0	2.00
	TOTALS		4,185,389	0	
<b>Q - Labor and Delivery Other</b>					
1.00	NURSERY	43.00		863,554	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00		639,293	2.00
			0	1,502,847	



RECLASSIFICATIONS

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

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		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
<b>R - Radiology Support Salary</b>						
1.00	RADIOLOGY-THERAPEUTIC	55.00	64,612		1.00	
2.00	CT SCAN	57.00	155,858		2.00	
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	33,736		3.00	
			254,206	0		
<b>S - Radiology Support Other</b>						
1.00	RADIOLOGY-THERAPEUTIC	55.00	0	36,669	1.00	
2.00	CT SCAN	57.00	0	88,454	2.00	
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	19,147	3.00	
			0	144,270		
<b>AA - STD AND WC BENEFIT RECLASS</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	61,153	1.00	
2.00	OPERATION OF PLANT	7.00	0	3,228	2.00	
3.00	HOUSEKEEPING	9.00	0	6,483	3.00	
4.00	DIETARY	10.00	0	5,842	4.00	
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,628	5.00	
6.00	SOCIAL SERVICE	17.00	0	12,279	6.00	
7.00	ADULTS & PEDIATRICS	30.00	0	172,291	7.00	
8.00	INTENSIVE CARE UNIT	31.00	0	19,166	8.00	
9.00	OPERATING ROOM	50.00	0	17,472	9.00	
10.00	RECOVERY ROOM	51.00	0	27,420	10.00	
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10,500	11.00	
12.00	RADIOLOGY-THERAPEUTIC	55.00	0	2,762	12.00	
13.00	CT SCAN	57.00	0	8,119	13.00	
14.00	CARDIAC CATHETERIZATION	59.00	0	3,340	14.00	
15.00	RESPIRATORY THERAPY	65.00	0	16,878	15.00	
16.00	PHYSICAL THERAPY	66.00	0	8,772	16.00	
17.00	ELECTROCARDIOLOGY	69.00	0	8,213	17.00	
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	493	18.00	
19.00	DRUGS CHARGED TO PATIENTS	73.00	0	35,752	19.00	
20.00	ENDOSCOPY	76.00	0	4,116	20.00	
21.00	IMAGING CENTER	76.06	0	1,843	21.00	
22.00	CARDIAC REHABILITATION	76.97	0	216	22.00	
23.00	ANTI-COAGULATION CLINIC	90.02	0	1,030	23.00	
24.00	EMERGENCY	91.00	0	26,517	24.00	
25.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	45	25.00	
			0	455,558		
500.00	Grand Total: Increases		5,217,504	41,952,421	500.00	

RECLASSIFICATIONS

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - Other Capital Rental Expense</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	77	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	69,278	0		2.00
3.00	OPERATION OF PLANT	7.00	0	5,088	0		3.00
4.00	HOUSEKEEPING	9.00	0	4,550	0		4.00
5.00	DIETARY	10.00	0	378	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	173	0		6.00
7.00	SOCIAL SERVICE	17.00	0	524	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	49,204	0		8.00
9.00	OPERATING ROOM	50.00	0	150,185	0		9.00
10.00	RECOVERY ROOM	51.00	0	4,653	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10,084	0		11.00
12.00	RADIOLOGY-THERAPEUTIC	55.00	0	381	0		12.00
13.00	CT SCAN	57.00	0	346	0		13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	124	0		14.00
15.00	CARDIAC CATHETERIZATION	59.00	0	2,527	0		15.00
16.00	LABORATORY	60.00	0	86	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	22,676	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	267,109	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	657	0		19.00
20.00	ELECTROENCEPHALOGRAPHY	70.00	0	75,765	0		20.00
21.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	868,624	0		21.00
22.00	DRUGS CHARGED TO PATIENTS	73.00	0	337,481	0		22.00
23.00	RENAL DIALYSIS	74.00	0	52	0		23.00
24.00	ENDOSCOPY	76.00	0	683	0		24.00
25.00	IMAGING CENTER	76.06	0	184,827	0		25.00
26.00	CARDIAC REHABILITATION	76.97	0	40	0		26.00
27.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	33,487	0		27.00
28.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	21,610	0		28.00
	0		0	2,110,669			
<b>B - Drugs Charges to Pat</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,996	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	162,293	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	17,041	0		3.00
4.00	OPERATING ROOM	50.00	0	48,378	0		4.00
5.00	RECOVERY ROOM	51.00	0	22,991	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	59,084	0		6.00
7.00	RADIOLOGY-THERAPEUTIC	55.00	0	179	0		7.00
8.00	CT SCAN	57.00	0	123,566	0		8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	37,138	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	67,723	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	2,479	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	1,099	0		12.00
13.00	ELECTROENCEPHALOGRAPHY	70.00	0	617	0		13.00
14.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	989	0		14.00
15.00	RENAL DIALYSIS	74.00	0	2,220	0		15.00
16.00	ENDOSCOPY	76.00	0	8,771	0		16.00
17.00	IMAGING CENTER	76.06	0	47,819	0		17.00
18.00	EMERGENCY	91.00	0	53,428	0		18.00
19.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	340	0		19.00
	0		0	660,151			
<b>C - Cafeteria Salary</b>							
1.00	DIETARY	10.00	777,909				1.00
			777,909	0			
<b>D - Cafeteria Other</b>							
1.00	DIETARY	10.00		502,137			1.00
			0	502,137			
<b>E - Therapy Salary</b>							
1.00	PHYSICAL THERAPY	66.00	0	530,807	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	530,807			
<b>F - Therapy Other</b>							
1.00	PHYSICAL THERAPY	66.00	0	170,596	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	170,596			

RECLASSIFICATIONS

Provider CCN: 15-0128

Period:  
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		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
<b>J - Implantable Device Recl ass</b>							
1.00	ADULTS & PEDI ATRICS	30.00	0	5,405	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	181	0		2.00
3.00	OPERATING ROOM	50.00	0	6,651,821	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	160,000	0		4.00
5.00	RADIOLOGY-THERAPEUTIC	55.00	0	178,347	0		5.00
6.00	CARDIAC CATHETERIZATION	59.00	0	2,445,933	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	5	0		7.00
8.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,087	0		8.00
9.00	ENDOSCOPY	76.00	0	4,009	0		9.00
10.00	EMERGENCY	91.00	0	13,812	0		10.00
	0		0	9,461,600			
<b>K - Medical Supplies</b>							
1.00	ADULTS & PEDI ATRICS	30.00	0	405,172	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	113,189	0		2.00
3.00	OPERATING ROOM	50.00	0	4,049,523	0		3.00
4.00	RECOVERY ROOM	51.00	0	12,978	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,306	0		5.00
6.00	RADIOLOGY-THERAPEUTIC	55.00	0	627,374	0		6.00
7.00	CT SCAN	57.00	0	116,654	0		7.00
8.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	4,511	0		8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	1,199,711	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	101,483	0		10.00
11.00	ELECTROCARDIOLOGY	69.00	0	103	0		11.00
12.00	RENAL DIALYSIS	74.00	0	26	0		12.00
13.00	ENDOSCOPY	76.00	0	176,061	0		13.00
14.00	IMAGING CENTER	76.06	0	29,448	0		14.00
15.00	EMERGENCY	91.00	0	58,510	0		15.00
	TOTALS		0	6,900,049			
<b>L - Depreciation Expense</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,513,627	9		1.00
2.00	OPERATION OF PLANT	7.00	0	47,724	0		2.00
3.00	HOUSEKEEPING	9.00	0	21,413	0		3.00
4.00	DIETARY	10.00	0	74,613	0		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	155	0		5.00
6.00	SOCIAL SERVICE	17.00	0	1,805	0		6.00
7.00	ADULTS & PEDI ATRICS	30.00	0	481,229	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	229,668	0		8.00
9.00	OPERATING ROOM	50.00	0	1,392,219	0		9.00
10.00	RECOVERY ROOM	51.00	0	51,636	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	367,455	0		11.00
12.00	RADIOLOGY-THERAPEUTIC	55.00	0	56,884	0		12.00
13.00	CT SCAN	57.00	0	293,243	0		13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	254,869	0		14.00
15.00	CARDIAC CATHETERIZATION	59.00	0	766,958	0		15.00
16.00	LABORATORY	60.00	0	2,173	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	112,160	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	171,785	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	81,216	0		19.00
20.00	ELECTROENCEPHALOGRAPHY	70.00	0	53,308	0		20.00
21.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	36,961	0		21.00
22.00	DRUGS CHARGED TO PATIENTS	73.00	0	30,132	0		22.00
23.00	ENDOSCOPY	76.00	0	293,000	0		23.00
24.00	IMAGING CENTER	76.06	0	321,653	0		24.00
25.00	CARDIAC REHABILITATION	76.97	0	3,853	0		25.00
26.00	ANTI-COAGULATION CLINIC	90.02	0	16,920	0		26.00
27.00	SPI NE CENTER	90.04	0	36	0		27.00
28.00	EMERGENCY	91.00	0	82,754	0		28.00
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	32,044	0		29.00
30.00	MISC NONREIMBURSABLE COST CENTERS	194.08	0	6,131	0		30.00
	0		0	9,797,624			
<b>M - Interest Expense</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,271,713	11		1.00
	0		0	4,271,713			
<b>N - Depreciation by CC</b>							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,294,218	9		1.00
	0		0	5,294,218			

RECLASSIFICATIONS

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet A-6

Date/Time Prepared:  
5/30/2017 10:50 am

Decreases						
Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.	
6.00	7.00	8.00	9.00	10.00		
<b>O - Capital Insurance Costs</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	150,182	12	1.00
	O		0	150,182		
<b>P - Labor and Delivery Salary</b>						
1.00	ADULTS & PEDIATRICS	30.00	4,185,389	0	0	1.00
2.00		0.00	0	0	0	2.00
	<b>TOTALS</b>		4,185,389	0		
<b>Q - Labor and Delivery Other</b>						
1.00	ADULTS & PEDIATRICS	30.00		1,502,847		1.00
2.00			0	1,502,847		2.00
<b>R - Radiology Support Salary</b>						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	254,206			1.00
2.00						2.00
3.00			254,206	0		3.00
<b>S - Radiology Support Other</b>						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	144,270	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	O		0	144,270		
<b>AA - STD AND WC BENEFIT RECLASS</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	61,153	0	0	1.00
2.00	OPERATION OF PLANT	7.00	3,228	0	0	2.00
3.00	HOUSEKEEPING	9.00	6,483	0	0	3.00
4.00	DIETARY	10.00	5,842	0	0	4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	1,628	0	0	5.00
6.00	SOCIAL SERVICE	17.00	12,279	0	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	172,291	0	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	19,166	0	0	8.00
9.00	OPERATING ROOM	50.00	17,472	0	0	9.00
10.00	RECOVERY ROOM	51.00	27,420	0	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	10,500	0	0	11.00
12.00	RADIOLOGY-THERAPEUTIC	55.00	2,762	0	0	12.00
13.00	CT SCAN	57.00	8,119	0	0	13.00
14.00	CARDIAC CATHETERIZATION	59.00	3,340	0	0	14.00
15.00	RESPIRATORY THERAPY	65.00	16,878	0	0	15.00
16.00	PHYSICAL THERAPY	66.00	8,772	0	0	16.00
17.00	ELECTROCARDIOLOGY	69.00	8,213	0	0	17.00
18.00	ELECTROENCEPHALOGRAPHY	70.00	493	0	0	18.00
19.00	DRUGS CHARGED TO PATIENTS	73.00	35,752	0	0	19.00
20.00	ENDOSCOPY	76.00	4,116	0	0	20.00
21.00	IMAGING CENTER	76.06	1,843	0	0	21.00
22.00	CARDIAC REHABILITATION	76.97	216	0	0	22.00
23.00	ANTI-COAGULATION CLINIC	90.02	1,030	0	0	23.00
24.00	EMERGENCY	91.00	26,517	0	0	24.00
25.00	PHYSICIANS' PRIVATE OFFICES	192.00	45	0	0	25.00
	O		455,558	0		
500.00	Grand Total: Decreases		5,673,062	41,496,863		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/30/2017 10:50 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	497,000	0	0	0	1.00
2.00	Land Improvements	2,722,362	0	0	497,000	2.00
3.00	Buildings and Fixtures	170,658,258	549,908	0	0	3.00
4.00	Building Improvements	2,710,911	0	0	928,727	4.00
5.00	Fixed Equipment	880,245	0	0	0	5.00
6.00	Movable Equipment	66,210,996	2,245,394	0	2,245,394	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	243,679,772	2,795,302	0	2,795,302	1,425,727
9.00	Reconciling Items	0	0	0	0	0
10.00	Total (line 8 minus line 9)	243,679,772	2,795,302	0	2,795,302	1,425,727
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	497,000	0			1.00
2.00	Land Improvements	2,225,362	0			2.00
3.00	Buildings and Fixtures	171,208,166	0			3.00
4.00	Building Improvements	1,782,184	0			4.00
5.00	Fixed Equipment	880,245	0			5.00
6.00	Movable Equipment	68,456,390	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	245,049,347	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	245,049,347	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/30/2017 10:50 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	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/30/2017 10:50 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	176,091,531	0	176,091,531	0.724112	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	67,091,241	0	67,091,241	0.275888	0	2.00
3.00	Total (sum of lines 1-2)	243,182,772	0	243,182,772	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	5,294,218	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	8,727,525	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	14,021,743	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	2,861,142	150,182	0	0	8,305,542	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	8,727,525	2.00
3.00	Total (sum of lines 1-2)	2,861,142	150,182	0	0	17,033,067	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet A-8

Date/Time Prepared:  
5/30/2017 10:50 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)			0		0.00		9	8.00
9.00 Parking lot (chapter 21)			0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-291,650					0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-1,406,744					0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests			0		0.00		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	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant			0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00			30.99
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 MISC REVENUE	B	-9,618		ADMINISTRATIVE & GENERAL	5.00		0	33.00
33.01 MISC REVENUE	B	-88,767		ADMINISTRATIVE & GENERAL	5.00		0	33.01



ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet A-8

Date/Time Prepared:  
5/30/2017 10:50 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.02 MISC REVENUE	B	-14,263	OPERATION OF PLANT	7.00	0	33.02
33.03 MISC REVENUE	B	-18,768	DIETARY	10.00	0	33.03
33.04 MISC REVENUE	B	-84,226	MEDICAL RECORDS & LIBRARY	16.00	0	33.04
33.05 MISC REVENUE	B	-90	ADULTS & PEDIATRICS	30.00	0	33.05
33.06 MISC REVENUE	B	-468,414	RADIOLOGY-DIAGNOSTIC	54.00	0	33.06
33.07 MISC REVENUE	B	-802,640	LABORATORY	60.00	0	33.07
33.08 MISC REVENUE	B	-69,106	PHYSICAL THERAPY	66.00	0	33.08
33.09 MISC REVENUE	B	-8,224	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.09
33.11 Disposal of Assets	B	168,808	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.11
33.12 Purchased Discounts	B	-5,018	ADMINISTRATIVE & GENERAL	5.00	0	33.12
34.01 Non-Allowable Interest Expense 00	A	-12,349	ADMINISTRATIVE & GENERAL	5.00	11	34.01
34.02 LOC Non-Allow Interest Expense	A	-30,884	CAP REL COSTS-BLDG & FIXT	1.00	11	34.02
34.03 2012A NON-ALLOW INTEREST EXPENSE	A	-1,134,916	CAP REL COSTS-BLDG & FIXT	1.00	11	34.03
34.04 2012B Non-Allow Interest Expense	A	-62,150	CAP REL COSTS-BLDG & FIXT	1.00	11	34.04
34.05 50M BMO Non-Allow Interest Expense	A	-110,477	CAP REL COSTS-BLDG & FIXT	1.00	11	34.05
34.06 2016A&B Non-Allow Interest Expense	A	-72,144	CAP REL COSTS-BLDG & FIXT	1.00	11	34.06
34.08 NON-ALLOWABLE DEBT ISSUANCE EXPENSE	A	-36,169	ADMINISTRATIVE & GENERAL	5.00	11	34.08
35.00 HAF Tax Offset	A	-7,919,009	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00 Meals of Wheels Cost	A	-91,815	CAFETERIA	11.00	0	36.00
36.01 Nurse Practitioner Offset	A	-224,064	ANTI-COAGULATION CLINIC	90.02	0	36.01
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-12,792,697				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: 15-0128  
 Period: From 01/01/2016 To 12/31/2016  
 Worksheet A-8-1  
 Date/Time Prepared: 5/30/2017 10:50 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		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>						
1.00	5.00	ADMINISTRATIVE & GENERAL	1550 CTY LN RD	47,478	39,420	1.00
2.00	30.00	ADULTS & PEDIATRICS	1550 CTY LN RD	80,766	67,057	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	CHNW - HOME OFFICE	1,949,133	0	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	CHNW - HOME OFFICE	2,381,520	0	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	CHNW - HOME OFFICE	25,369,739	38,872,524	3.02
3.03	7.00	OPERATION OF PLANT	CHNW - HOME OFFICE	513,056	0	3.03
3.04	13.00	NURSING ADMINISTRATION	CHNW - HOME OFFICE	1,498,380	0	3.04
3.05	71.00	MEDICAL SUPPLIES CHARGED TO	CHNW - HOME OFFICE	684,703	0	3.05
3.06	16.00	MEDICAL RECORDS & LIBRARY	CHNW - HOME OFFICE	1,880,406	0	3.06
3.07	30.00	ADULTS & PEDIATRICS	CHNW - HOME OFFICE	662,823	0	3.07
3.08	54.00	RADIOLOGY-DIAGNOSTIC	CHNW - HOME OFFICE	431,894	0	3.08
3.09	69.00	ELECTROCARDIOLOGY	CHNW - HOME OFFICE	72,498	0	3.09
3.10	70.00	ELECTROENCEPHALOGRAPHY	CHNW - HOME OFFICE	100,889	0	3.10
3.11	73.00	DRUGS CHARGED TO PATIENTS	CHNW - HOME OFFICE	538,220	0	3.11
4.00	21.00	I&R SERVICES-SALARY & FRINGE	INTERNS & RESIDENTS	495,162	0	4.00
4.01	22.00	I&R SERVICES-OTHER PRGM. COS	INTERNS & RESIDENTS	865,590	0	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			37,572,257	38,979,001	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.

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

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	C	CHNW	100.00	0.00	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:	OTHER			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: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet A-8-1 Date/Time Prepared: 5/30/2017 10:50 am
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	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>			
1.00	8,058	0	1.00
2.00	13,709	0	2.00
3.00	1,949,133	9	3.00
3.01	2,381,520	0	3.01
3.02	-13,502,785	0	3.02
3.03	513,056	0	3.03
3.04	1,498,380	0	3.04
3.05	684,703	0	3.05
3.06	1,880,406	0	3.06
3.07	662,823	0	3.07
3.08	431,894	0	3.08
3.09	72,498	0	3.09
3.10	100,889	0	3.10
3.11	538,220	0	3.11
4.00	495,162	0	4.00
4.01	865,590	0	4.01
5.00	-1,406,744		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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>	

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

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

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

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
  - B. Corporation, partnership, or other organization has financial interest in provider.
  - C. Provider has financial interest in corporation, partnership, or other organization.
  - D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
  - E. Individual is director, officer, administrator, or key person of provider and related organization.
  - F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet A-8-2

Date/Time Prepared:  
5/30/2017 10:50 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	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	291,650	291,650	0	237,100	0	1.00
2.00	0.00		0	0	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			291,650	291,650	0		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	1.00
2.00	0.00		0	0	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			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0	0	291,650		1.00
2.00	0.00		0	0	0	0		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	0	0	291,650		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2017 10:50 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	8,305,542	8,305,542			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	8,727,525		8,727,525		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,620,807	0	50	2,620,857	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	50,261,465	867,887	3,754,474	177,661	55,061,487
7.00 00700	OPERATION OF PLANT	3,999,944	1,212,260	34,280	62,391	5,308,875
8.00 00800	LAUNDRY & LINEN SERVICE	586,684	22,226	0	0	608,910
9.00 00900	HOUSEKEEPING	2,144,985	49,327	16,853	59,750	2,270,915
10.00 01000	DIETARY	608,880	87,212	16,180	18,112	730,384
11.00 01100	CAFETERIA	1,188,231	177,847	32,497	37,512	1,436,087
13.00 01300	NURSING ADMINISTRATION	1,798,894	0	0	11,973	1,810,867
16.00 01600	MEDICAL RECORDS & LIBRARY	2,096,609	38,741	213	10,004	2,145,567
17.00 01700	SOCIAL SERVICE	1,834,362	22,763	1,511	66,380	1,925,016
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	495,162	0	0	0	495,162
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	865,590	0	0	0	865,590
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	28,145,610	1,943,031	270,095	729,720	31,088,456
31.00 03100	INTENSIVE CARE UNIT	3,054,111	630,246	149,077	104,863	3,938,297
43.00 04300	NURSERY	3,268,528	309,850	42,640	115,973	3,736,991
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	8,855,526	699,371	1,050,811	135,030	10,740,738
51.00 05100	RECOVERY ROOM	3,552,711	172,674	36,537	118,746	3,880,668
52.00 05200	DELIVERY ROOM & LABOR ROOM	2,643,752	229,383	31,567	105,228	3,009,930
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,491,273	248,664	245,059	69,095	3,054,091
55.00 05500	RADIOLOGY-THERAPEUTIC	1,018,252	0	37,171	29,833	1,085,256
57.00 05700	CT SCAN	1,242,455	30,583	190,568	32,262	1,495,868
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	537,753	38,841	165,515	11,364	753,473
59.00 05900	CARDIAC CATHETERIZATION	2,629,694	224,170	499,470	53,630	3,406,964
60.00 06000	LABORATORY	5,062,921	104,603	1,466	0	5,168,990
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	2,399,570	52,530	87,522	76,547	2,616,169
66.00 06600	PHYSICAL THERAPY	1,677,256	17,888	368,039	88,936	2,152,119
67.00 06700	OCCUPATIONAL THERAPY	566,233	5,790	25,785	0	597,808
68.00 06800	SPEECH PATHOLOGY	135,170	1,393	6,155	0	142,718
69.00 06900	ELECTROCARDIOLOGY	1,135,807	129,754	53,144	35,422	1,354,127
70.00 07000	ELECTROENCEPHALOGRAPHY	815,584	50,839	83,782	20,090	970,295
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,431,767	235,710	587,813	0	8,255,290
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	9,461,600	0	0	0	9,461,600
73.00 07300	DRUGS CHARGED TO PATIENTS	10,834,877	29,668	238,616	118,474	11,221,635
74.00 07400	RENAL DIALYSIS	370,896	25,808	34	36	396,774
76.00 03950	ENDOSCOPY	1,127,856	0	190,629	26,333	1,344,818
76.06 03330	IMAGING CENTER	1,448,039	0	402,991	33,459	1,884,489
76.97 07697	CARDIAC REHABILITATION	248,499	0	2,527	9,104	260,130
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	0
90.01 04950	DIABETIC CARE CENTER	0	0	0	0	0
90.02 04951	ANTI-COAGULATION CLINIC	434,679	0	10,983	24,557	470,219
90.03 04952	PALLIATIVE CARE	0	0	0	0	0
90.04 04953	SPINE CENTER	162,892	0	23	5,839	168,754
91.00 09100	EMERGENCY	7,591,388	608,836	50,800	214,451	8,465,475
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	193,879,379	8,267,895	8,684,877	2,602,775	193,781,002
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00 19100	RESEARCH	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	625,635	0	42,536	9,777	677,948
193.00 19300	NONPAID WORKERS	0	0	0	0	0
194.00 07950	HOME OFFICE	0	0	0	0	0
194.06 07956	LEASED OFFICE SPACE	0	0	0	0	0
194.08 07958	MISC NONREIMBURSABLE COST CENTERS	254,994	37,647	112	8,305	301,058
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	194,760,008	8,305,542	8,727,525	2,620,857	194,760,008

COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prepared: 5/30/2017 10:50 am		
Cost Center Description				ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
				5.00	7.00	8.00	9.00	10.00
<b>GENERAL SERVICE COST CENTERS</b>								
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	55,061,487					5.00
7.00	00700	OPERATION OF PLANT	2,092,467	7,401,342				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	239,999	26,424	875,333			8.00
9.00	00900	HOUSEKEEPING	895,070	58,644	0	3,224,629		9.00
10.00	01000	DIETARY	287,877	103,686	0	45,700	1,167,647	10.00
11.00	01100	CAFETERIA	566,027	211,442	0	93,192	0	11.00
13.00	01300	NURSING ADMINISTRATION	713,744	0	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	845,665	46,059	0	20,300	0	16.00
17.00	01700	SOCIAL SERVICE	758,735	27,063	0	11,928	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	195,166	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	341,168	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	12,253,371	2,310,063	343,869	1,018,153	1,083,399	30.00
31.00	03100	INTENSIVE CARE UNIT	1,552,260	749,296	44,602	330,250	84,248	31.00
43.00	04300	NURSERY	1,472,916	368,379	64,061	162,362	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	4,233,408	831,479	82,366	366,472	0	50.00
51.00	05100	RECOVERY ROOM	1,529,546	205,291	0	90,482	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,186,349	272,712	47,422	120,197	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,203,755	295,635	13,699	130,301	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	427,748	0	9,545	0	0	55.00
57.00	05700	CT SCAN	589,589	36,360	0	16,026	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	296,978	46,178	42,614	20,353	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,342,838	266,514	1,559	117,465	0	59.00
60.00	06000	LABORATORY	2,037,332	124,362	0	54,812	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,031,150	62,453	0	27,526	0	65.00
66.00	06600	PHYSICAL THERAPY	848,247	21,267	0	9,373	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	235,623	6,884	0	3,034	0	67.00
68.00	06800	SPEECH PATHOLOGY	56,252	1,656	0	730	0	68.00
69.00	06900	ELECTROCARDIOLOGY	533,722	154,264	0	67,992	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	382,437	60,442	0	26,640	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,253,781	280,235	0	123,513	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,729,242	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,422,951	35,272	0	15,546	0	73.00
74.00	07400	RENAL DIALYSIS	156,386	30,682	0	13,523	0	74.00
76.00	03950	ENDOSCOPY	530,053	0	0	0	0	76.00
76.06	03330	IMAGING CENTER	742,762	0	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	102,529	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	185,334	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	66,514	0	0	0	0	90.04
91.00	09100	EMERGENCY	3,336,625	723,842	225,596	319,032	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	54,675,616	7,356,584	875,333	3,204,902	1,167,647	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	267,210	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	LEASED OFFICE SPACE	0	0	0	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	118,661	44,758	0	19,727	0	194.08
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)	55,061,487	7,401,342	875,333	3,224,629	1,167,647	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0128

Period: From 01/01/2016 To 12/31/2016

Worksheet B Part I Date/Time Prepared: 5/30/2017 10:50 am

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES		
	11.00	13.00	16.00	17.00	21.00		
<b>GENERAL SERVICE COST CENTERS</b>							
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	
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	2,306,748					11.00	
13.00 01300 NURSING ADMINISTRATION	28,879	2,553,490				13.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	10,830	0	3,068,421			16.00	
17.00 01700 SOCIAL SERVICE	68,589	0	0	2,791,331		17.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	690,328	21.00	
22.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	826,675	1,651,834	330,392	2,247,742	499,857	30.00	
31.00 03100 INTENSIVE CARE UNIT	86,638	173,118	31,935	180,100	34,727	31.00	
43.00 04300 NURSERY	115,518	230,824	56,677	363,489	0	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	155,227	0	342,290	0	35,779	50.00	
51.00 05100 RECOVERY ROOM	108,298	0	113,329	0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	86,638	0	40,309	0	0	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	79,419	0	124,876	0	16,837	54.00	
55.00 05500 RADIOLOGY-THERAPEUTIC	25,270	0	72,181	0	0	55.00	
57.00 05700 CT SCAN	39,709	0	198,197	0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	14,440	0	42,060	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	50,539	0	177,621	0	0	59.00	
60.00 06000 LABORATORY	0	0	267,131	0	0	60.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	86,638	0	49,785	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	32,489	0	32,089	0	6,314	66.00	
67.00 06700 OCCUPATIONAL THERAPY	21,660	0	10,898	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	3,610	0	2,602	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	54,149	0	71,539	0	26,308	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	21,660	0	19,629	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	138,074	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	145,719	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	101,078	0	248,330	0	0	73.00	
74.00 07400 RENAL DIALYSIS	0	0	4,513	0	0	74.00	
76.00 03950 ENDOSCOPY	21,660	0	40,346	0	0	76.00	
76.06 03330 IMAGING CENTER	3,610	0	50,732	0	0	76.06	
76.97 07697 CARDIAC REHABILITATION	14,440	0	4,360	0	0	76.97	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	0	0	0	0	0	90.00	
90.01 04950 DIABETIC CARE CENTER	0	0	0	0	0	90.01	
90.02 04951 ANTI-COAGULATION CLINIC	0	0	5,665	0	0	90.02	
90.03 04952 PALLIATIVE CARE	0	0	0	0	0	90.03	
90.04 04953 SPINE CENTER	0	0	1,653	0	0	90.04	
91.00 09100 EMERGENCY	249,085	497,714	445,489	0	70,506	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,306,748	2,553,490	3,068,421	2,791,331	690,328	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
191.00 19100 RESEARCH	0	0	0	0	0	191.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00	
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00	
194.00 07950 HOME OFFICE	0	0	0	0	0	194.00	
194.06 07956 LEASED OFFICE SPACE	0	0	0	0	0	194.06	
194.08 07958 MISC NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.08	
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	2,306,748	2,553,490	3,068,421	2,791,331	690,328	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2017 10:50 am

Cost Center Description		INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		22.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>						
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
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	1,206,758			22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	873,797	54,527,608	-1,373,654	53,153,954
31.00	03100	INTENSIVE CARE UNIT	60,706	7,266,177	-95,433	7,170,744
43.00	04300	NURSERY	0	6,571,217	0	6,571,217
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	62,545	16,850,304	-98,324	16,751,980
51.00	05100	RECOVERY ROOM	0	5,927,614	0	5,927,614
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,763,557	0	4,763,557
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,433	4,948,046	-46,270	4,901,776
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,620,000	0	1,620,000
57.00	05700	CT SCAN	0	2,375,749	0	2,375,749
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,216,096	0	1,216,096
59.00	05900	CARDIAC CATHETERIZATION	0	5,363,500	0	5,363,500
60.00	06000	LABORATORY	0	7,652,627	0	7,652,627
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	3,873,721	0	3,873,721
66.00	06600	PHYSICAL THERAPY	11,037	3,112,935	-17,351	3,095,584
67.00	06700	OCCUPATIONAL THERAPY	0	875,907	0	875,907
68.00	06800	SPEECH PATHOLOGY	0	207,568	0	207,568
69.00	06900	ELECTROCARDIOLOGY	45,989	2,308,090	-72,297	2,235,793
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,481,103	0	1,481,103
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,050,893	0	12,050,893
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,336,561	0	13,336,561
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,044,812	0	16,044,812
74.00	07400	RENAL DIALYSIS	0	601,878	0	601,878
76.00	03950	ENDOSCOPY	0	1,936,877	0	1,936,877
76.06	03330	IMAGING CENTER	0	2,681,593	0	2,681,593
76.97	07697	CARDIAC REHABILITATION	0	381,459	0	381,459
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	0	0	0
90.01	04950	DIABETIC CARE CENTER	0	0	0	0
90.02	04951	ANTI-COAGULATION CLINIC	0	661,218	0	661,218
90.03	04952	PALLIATIVE CARE	0	0	0	0
90.04	04953	SPINE CENTER	0	236,921	0	236,921
91.00	09100	EMERGENCY	123,251	14,456,615	-193,757	14,262,858
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,206,758	193,330,646	-1,897,086	191,433,560
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	945,158	0	945,158
193.00	19300	NONPAID WORKERS	0	0	0	0
194.00	07950	HOME OFFICE	0	0	0	0
194.06	07956	LEASED OFFICE SPACE	0	0	0	0
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	0	484,204	0	484,204
200.00		Cross Foot Adjustments	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,206,758	194,760,008	-1,897,086	192,862,922



ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet B  
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
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	50	50	50	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	867,887	3,754,474	4,622,361	5.00
7.00 00700	OPERATION OF PLANT	0	1,212,260	34,280	1,246,540	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	22,226	0	22,226	8.00
9.00 00900	HOUSEKEEPING	0	49,327	16,853	66,180	9.00
10.00 01000	DIETARY	0	87,212	16,180	103,392	10.00
11.00 01100	CAFETERIA	0	177,847	32,497	210,344	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	38,741	213	38,954	16.00
17.00 01700	SOCIAL SERVICE	0	22,763	1,511	24,274	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	1,943,031	270,095	2,213,126	30.00
31.00 03100	INTENSIVE CARE UNIT	0	630,246	149,077	779,323	31.00
43.00 04300	NURSERY	0	309,850	42,640	352,490	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	699,371	1,050,811	1,750,182	50.00
51.00 05100	RECOVERY ROOM	0	172,674	36,537	209,211	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	229,383	31,567	260,950	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	248,664	245,059	493,723	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	37,171	37,171	55.00
57.00 05700	CT SCAN	0	30,583	190,568	221,151	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	38,841	165,515	204,356	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	224,170	499,470	723,640	59.00
60.00 06000	LABORATORY	0	104,603	1,466	106,069	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	52,530	87,522	140,052	65.00
66.00 06600	PHYSICAL THERAPY	0	17,888	368,039	385,927	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	5,790	25,785	31,575	67.00
68.00 06800	SPEECH PATHOLOGY	0	1,393	6,155	7,548	68.00
69.00 06900	ELECTROCARDIOLOGY	0	129,754	53,144	182,898	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	50,839	83,782	134,621	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	235,710	587,813	823,523	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	29,668	238,616	268,284	73.00
74.00 07400	RENAL DIALYSIS	0	25,808	34	25,842	74.00
76.00 03950	ENDOSCOPY	0	0	190,629	190,629	76.00
76.06 03330	IMAGING CENTER	0	0	402,991	402,991	76.06
76.97 07697	CARDIAC REHABILITATION	0	0	2,527	2,527	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 04950	DIABETIC CARE CENTER	0	0	0	0	90.01
90.02 04951	ANTI-COAGULATION CLINIC	0	0	10,983	10,983	90.02
90.03 04952	PALLIATIVE CARE	0	0	0	0	90.03
90.04 04953	SPINE CENTER	0	0	23	23	90.04
91.00 09100	EMERGENCY	0	608,836	50,800	659,636	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	8,267,895	8,684,877	16,952,772	50 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	42,536	42,536	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	0	194.00
194.06 07956	LEASED OFFICE SPACE	0	0	0	0	194.06
194.08 07958	MISC NONREIMBURSABLE COST CENTERS	0	37,647	112	37,759	194.08
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	8,305,542	8,727,525	17,033,067	50 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet B  
Part II  
Date/Time Prepared:  
5/30/2017 10:50 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
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	4,622,365				5.00	
7.00	00700	OPERATION OF PLANT	175,660	1,422,201			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	20,148	5,078	47,452		8.00	
9.00	00900	HOUSEKEEPING	75,140	11,269	0	152,590	9.00	
10.00	01000	DIETARY	24,167	19,924	0	2,163	10.00	
11.00	01100	CAFETERIA	47,517	40,630	0	4,410	11.00	
13.00	01300	NURSING ADMINISTRATION	59,918	0	0	0	13.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	70,993	8,850	0	961	16.00	
17.00	01700	SOCIAL SERVICE	63,695	5,200	0	564	17.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	16,384	0	0	0	21.00	
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	28,641	0	0	0	22.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,028,674	443,886	18,640	48,175	30.00	
31.00	03100	INTENSIVE CARE UNIT	130,310	143,981	2,418	15,628	31.00	
43.00	04300	NURSERY	123,650	70,786	3,473	7,683	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	355,390	159,772	4,465	17,342	50.00	
51.00	05100	RECOVERY ROOM	128,404	39,448	0	4,282	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	99,593	52,403	2,571	5,688	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	101,054	56,808	743	6,166	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	35,909	0	517	0	55.00	
57.00	05700	CT SCAN	49,495	6,987	0	758	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	24,931	8,873	2,310	963	58.00	
59.00	05900	CARDIAC CATHETERIZATION	112,730	51,212	85	5,558	59.00	
60.00	06000	LABORATORY	171,032	23,897	0	2,594	60.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	86,564	12,001	0	1,303	65.00	
66.00	06600	PHYSICAL THERAPY	71,209	4,087	0	444	66.00	
67.00	06700	OCCUPATIONAL THERAPY	19,780	1,323	0	144	67.00	
68.00	06800	SPEECH PATHOLOGY	4,722	318	0	35	68.00	
69.00	06900	ELECTROCARDIOLOGY	44,805	29,643	0	3,217	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	32,105	11,614	0	1,261	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	273,151	53,848	0	5,845	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	313,065	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	371,301	6,778	0	736	73.00	
74.00	07400	RENAL DIALYSIS	13,128	5,896	0	640	74.00	
76.00	03950	ENDOSCOPY	44,497	0	0	0	76.00	
76.06	03330	IMAGING CENTER	62,354	0	0	0	76.06	
76.97	07697	CARDIAC REHABILITATION	8,607	0	0	0	76.97	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	90.00	
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	90.01	
90.02	04951	ANTI-COAGULATION CLINIC	15,559	0	0	0	90.02	
90.03	04952	PALLIATIVE CARE	0	0	0	0	90.03	
90.04	04953	SPINE CENTER	5,584	0	0	0	90.04	
91.00	09100	EMERGENCY	280,106	139,089	12,230	15,097	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00	
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,589,972	1,413,601	47,452	151,657	149,646	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,432	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	LEASED OFFICE SPACE	0	0	0	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	9,961	8,600	0	933	0	194.08
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)	4,622,365	1,422,201	47,452	152,590	149,646	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/30/2017 10:50 am		
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES
		11.00	13.00	16.00	17.00	21.00
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100	302,902				11.00
13.00	01300	3,792	63,710			13.00
16.00	01600	1,422	0	121,180		16.00
17.00	01700	9,006	0	0	102,740	17.00
21.00	02100	0	0	0	0	21.00
22.00	02200	0	0	0	0	16,384
22.00	02200	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	108,552	41,214	13,040	82,732	30.00
31.00	03100	11,377	4,319	1,260	6,629	31.00
43.00	04300	15,169	5,759	2,237	13,379	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	20,383	0	13,509	0	50.00
51.00	05100	14,221	0	4,473	0	51.00
52.00	05200	11,377	0	1,591	0	52.00
54.00	05400	10,429	0	4,928	0	54.00
55.00	05500	3,318	0	2,849	0	55.00
57.00	05700	5,214	0	7,822	0	57.00
58.00	05800	1,896	0	1,660	0	58.00
59.00	05900	6,636	0	7,010	0	59.00
60.00	06000	0	0	10,543	0	60.00
64.00	06400	0	0	0	0	64.00
65.00	06500	11,377	0	1,965	0	65.00
66.00	06600	4,266	0	1,266	0	66.00
67.00	06700	2,844	0	430	0	67.00
68.00	06800	474	0	103	0	68.00
69.00	06900	7,110	0	2,823	0	69.00
70.00	07000	2,844	0	775	0	70.00
71.00	07100	0	0	5,449	0	71.00
72.00	07200	0	0	5,751	0	72.00
73.00	07300	13,273	0	9,801	0	73.00
74.00	07400	0	0	178	0	74.00
76.00	03950	2,844	0	1,592	0	76.00
76.06	03330	474	0	2,002	0	76.06
76.97	07697	1,896	0	172	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	0	0	0	0	90.00
90.01	04950	0	0	0	0	90.01
90.02	04951	0	0	224	0	90.02
90.03	04952	0	0	0	0	90.03
90.04	04953	0	0	65	0	90.04
91.00	09100	32,708	12,418	17,662	0	91.00
92.00	09200	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		302,902	63,710	121,180	102,740	0
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	0	0	0	190.00
191.00	19100	0	0	0	0	191.00
192.00	19200	0	0	0	0	192.00
193.00	19300	0	0	0	0	193.00
194.00	07950	0	0	0	0	194.00
194.06	07956	0	0	0	0	194.06
194.08	07958	0	0	0	0	194.08
200.00		0	0	0	0	16,384
201.00		0	0	0	0	0
202.00		302,902	63,710	121,180	102,740	16,384

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/30/2017 10:50 am
Cost Center Description	INTERNS & RESIDENTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	SERVICES-OTHER PRGM. COSTS				
	22.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
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
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	28,641		22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	4,136,901	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,106,044	0	31.00
43.00	04300	NURSERY	594,628	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	2,321,046	0	50.00
51.00	05100	RECOVERY ROOM	400,041	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	434,175	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	673,852	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	79,765	0	55.00
57.00	05700	CT SCAN	291,428	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	244,989	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	906,872	0	59.00
60.00	06000	LABORATORY	314,135	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	253,264	0	65.00
66.00	06600	PHYSICAL THERAPY	467,201	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	56,096	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,200	0	68.00
69.00	06900	ELECTROCARDIOLOGY	270,497	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	183,220	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,161,816	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	318,816	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	670,175	0	73.00
74.00	07400	RENAL DIALYSIS	45,684	0	74.00
76.00	03950	ENDOSCOPY	239,563	0	76.00
76.06	03330	IMAGING CENTER	467,822	0	76.06
76.97	07697	CARDIAC REHABILITATION	13,202	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	26,767	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	90.03
90.04	04953	SPINE CENTER	5,672	0	90.04
91.00	09100	EMERGENCY	1,168,950	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	16,865,821	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	64,968	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	HOME OFFICE	0	0	194.00
194.06	07956	LEASED OFFICE SPACE	0	0	194.06
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	57,253	0	194.08
200.00		Cross Foot Adjustments	28,641	45,025	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118-201)	28,641	17,033,067	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet B-1  
Date/Time Prepared:  
5/30/2017 10:50 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	CAP REL COSTS-BLDG & FIXT	417,408					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		13,445,636				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	77	54,350,200			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	43,617	5,784,145	3,684,239	-55,061,487	139,698,521	5.00
7.00 00700	OPERATION OF PLANT	60,924	52,812	1,293,832	0	5,308,875	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,117	0	0	0	608,910	8.00
9.00 00900	HOUSEKEEPING	2,479	25,963	1,239,055	0	2,270,915	9.00
10.00 01000	DIETARY	4,383	24,927	375,591	0	730,384	10.00
11.00 01100	CAFETERIA	8,938	50,065	777,909	0	1,436,087	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	248,291	0	1,810,867	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,947	328	207,467	0	2,145,567	16.00
17.00 01700	SOCIAL SERVICE	1,144	2,328	1,376,560	0	1,925,016	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	495,162	21.00
22.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	865,590	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	97,650	416,109	15,132,920	0	31,088,456	30.00
31.00 03100	INTENSIVE CARE UNIT	31,674	229,668	2,174,580	0	3,938,297	31.00
43.00 04300	NURSERY	15,572	65,692	2,404,974	0	3,736,991	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	35,148	1,618,882	2,800,180	0	10,740,738	50.00
51.00 05100	RECOVERY ROOM	8,678	56,289	2,462,476	0	3,880,668	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	11,528	48,632	2,182,150	0	3,009,930	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	12,497	377,539	1,432,859	0	3,054,091	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	57,265	618,667	0	1,085,256	55.00
57.00 05700	CT SCAN	1,537	293,589	669,035	0	1,495,868	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,952	254,993	235,655	0	753,473	58.00
59.00 05900	CARDIAC CATHETERIZATION	11,266	769,485	1,112,142	0	3,406,964	59.00
60.00 06000	LABORATORY	5,257	2,259	0	0	5,168,990	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	2,640	134,836	1,587,389	0	2,616,169	65.00
66.00 06600	PHYSICAL THERAPY	899	567,001	1,844,301	0	2,152,119	66.00
67.00 06700	OCCUPATIONAL THERAPY	291	39,724	0	0	597,808	67.00
68.00 06800	SPEECH PATHOLOGY	70	9,483	0	0	142,718	68.00
69.00 06900	ELECTROCARDIOLOGY	6,521	81,873	734,555	0	1,354,127	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	2,555	129,074	416,614	0	970,295	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,846	905,585	0	0	8,255,290	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9,461,600	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,491	367,613	2,456,845	0	11,221,635	73.00
74.00 07400	RENAL DIALYSIS	1,297	52	738	0	396,774	74.00
76.00 03950	ENDOSCOPY	0	293,683	546,075	0	1,344,818	76.00
76.06 03330	IMAGING CENTER	0	620,849	693,847	0	1,884,489	76.06
76.97 07697	CARDIAC REHABILITATION	0	3,893	188,786	0	260,130	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000	CLINIC	0	0	0	0	0	90.00
90.01 04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02 04951	ANTI-COAGULATION CLINIC	0	16,920	509,247	0	470,219	90.02
90.03 04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04 04953	SPINE CENTER	0	36	121,090	0	168,754	90.04
91.00 09100	EMERGENCY	30,598	78,263	4,447,158	0	8,465,475	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	415,516	13,379,932	53,975,227	-55,061,487	138,719,515	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	65,531	202,756	0	677,948	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	HOME OFFICE	0	0	0	0	0	194.00
194.06 07956	LEASED OFFICE SPACE	0	0	0	0	0	194.06
194.08 07958	MISC NONREIMBURSABLE COST CENTERS	1,892	173	172,217	0	301,058	194.08
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)	8,305,542	8,727,525	2,620,857		55,061,487	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	19.897898	0.649097	0.048222		0.394145	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			50		4,622,365	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet B-1

Date/Time Prepared:  
5/30/2017 10:50 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
205.00	Unit cost multiplier (Wkst. B, Part II)		0.000001	5A	0.033088	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet B-1

Date/Time Prepared:  
5/30/2017 10:50 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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
7.00	00700	OPERATION OF PLANT	312,867				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,117	147,094			8.00
9.00	00900	HOUSEKEEPING	2,479	0	309,271		9.00
10.00	01000	DIETARY	4,383	0	4,383	34,150	10.00
11.00	01100	CAFETERIA	8,938	0	8,938	0	639
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	8
16.00	01600	MEDICAL RECORDS & LIBRARY	1,947	0	1,947	0	3
17.00	01700	SOCIAL SERVICE	1,144	0	1,144	0	19
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	97,650	57,785	97,650	31,686	229
31.00	03100	INTENSIVE CARE UNIT	31,674	7,495	31,674	2,464	24
43.00	04300	NURSERY	15,572	10,765	15,572	0	32
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	35,148	13,841	35,148	0	43
51.00	05100	RECOVERY ROOM	8,678	0	8,678	0	30
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,528	7,969	11,528	0	24
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,497	2,302	12,497	0	22
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,604	0	0	7
57.00	05700	CT SCAN	1,537	0	1,537	0	11
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,952	7,161	1,952	0	4
59.00	05900	CARDIAC CATHETERIZATION	11,266	262	11,266	0	14
60.00	06000	LABORATORY	5,257	0	5,257	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	2,640	0	2,640	0	24
66.00	06600	PHYSICAL THERAPY	899	0	899	0	9
67.00	06700	OCCUPATIONAL THERAPY	291	0	291	0	6
68.00	06800	SPEECH PATHOLOGY	70	0	70	0	1
69.00	06900	ELECTROCARDIOLOGY	6,521	0	6,521	0	15
70.00	07000	ELECTROENCEPHALOGRAPHY	2,555	0	2,555	0	6
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,846	0	11,846	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,491	0	1,491	0	28
74.00	07400	RENAL DIALYSIS	1,297	0	1,297	0	0
76.00	03950	ENDOSCOPY	0	0	0	0	6
76.06	03330	IMAGING CENTER	0	0	0	0	1
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	4
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	0	0
90.03	04952	PALLIATIVE CARE	0	0	0	0	0
90.04	04953	SPINE CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	30,598	37,910	30,598	0	69
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	310,975	147,094	307,379	34,150	639
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	HOME OFFICE	0	0	0	0	0
194.06	07956	LEASED OFFICE SPACE	0	0	0	0	0
194.08	07958	MISC NONREIMBURSABLE COST CENTERS	1,892	0	1,892	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	7,401,342	875,333	3,224,629	1,167,647	2,306,748
203.00		Unit cost multiplier (Wkst. B, Part I)	23.656512	5.950841	10.426548	34.191713	3,609.934272
204.00		Cost to be allocated (per Wkst. B, Part II)	1,422,201	47,452	152,590	149,646	302,902
205.00		Unit cost multiplier (Wkst. B, Part II)	4.545705	0.322596	0.493386	4.382020	474.025039

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet B-1  
Date/Time Prepared:  
5/30/2017 10:50 am

Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS			
				SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
				13.00	16.00		17.00
<b>GENERAL SERVICE COST CENTERS</b>							
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	
7.00 00700 OPERATION OF PLANT						7.00	
8.00 00800 LAUNDRY & LINEN SERVICE						8.00	
9.00 00900 HOUSEKEEPING						9.00	
10.00 01000 DIETARY						10.00	
11.00 01100 CAFETERIA						11.00	
13.00 01300 NURSING ADMINISTRATION	354					13.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	0	786,426,322				16.00	
17.00 01700 SOCIAL SERVICE	0	0	38,189			17.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	656		21.00	
22.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	656	22.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	229	84,672,557	30,752	475	475	30.00	
31.00 03100 INTENSIVE CARE UNIT	24	8,184,315	2,464	33	33	31.00	
43.00 04300 NURSERY	32	14,525,016	4,973	0	0	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	0	87,721,755	0	34	34	50.00	
51.00 05100 RECOVERY ROOM	0	29,043,815	0	0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	10,330,424	0	0	0	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	32,002,951	0	16	16	54.00	
55.00 05500 RADIOLOGY-THERAPEUTIC	0	18,498,420	0	0	0	55.00	
57.00 05700 CT SCAN	0	50,793,804	0	0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	10,779,005	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	45,520,575	0	0	0	59.00	
60.00 06000 LABORATORY	0	68,459,919	0	0	0	60.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	0	12,758,798	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	0	8,223,748	0	6	6	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	2,792,822	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0	666,761	0	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	18,334,006	0	25	25	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	5,030,459	0	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	35,385,408	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	37,344,815	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	63,641,663	0	0	0	73.00	
74.00 07400 RENAL DIALYSIS	0	1,156,599	0	0	0	74.00	
76.00 03950 ENDOSCOPY	0	10,339,825	0	0	0	76.00	
76.06 03330 IMAGING CENTER	0	13,001,541	0	0	0	76.06	
76.97 07697 CARDIAC REHABILITATION	0	1,117,305	0	0	0	76.97	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	0	0	0	0	0	90.00	
90.01 04950 DIABETIC CARE CENTER	0	0	0	0	0	90.01	
90.02 04951 ANTI-COAGULATION CLINIC	0	1,451,914	0	0	0	90.02	
90.03 04952 PALLIATIVE CARE	0	0	0	0	0	90.03	
90.04 04953 SPINE CENTER	0	423,750	0	0	0	90.04	
91.00 09100 EMERGENCY	69	114,224,352	0	67	67	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	354	786,426,322	38,189	656	656	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
191.00 19100 RESEARCH	0	0	0	0	0	191.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00	
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00	
194.00 07950 HOME OFFICE	0	0	0	0	0	194.00	
194.06 07956 LEASED OFFICE SPACE	0	0	0	0	0	194.06	
194.08 07958 MISC NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.08	
200.00	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers					201.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	2,553,490	3,068,421	2,791,331	690,328	1,206,758	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	7,213.248588	0.003902	73.092540	1,052.329268	1,839.570122	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	63,710	121,180	102,740	16,384	28,641	204.00



COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet B-1  
Date/Time Prepared:  
5/30/2017 10:50 am

Cost Center Description	NURSING ADMINISTRATION  (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE  (TOTAL PATIENT DAYS)	INTERNS & RESIDENTS		
				SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)	
				13.00	16.00	
205.00   Unit cost multiplier (Wkst. B, Part II)	179.971751	0.000154	2.690303	24.975610	43.660061	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/30/2017 10:50 am
		Title XVIII	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		53,153,954	0	53,153,954	30.00
31.00	03100 INTENSIVE CARE UNIT		7,170,744	0	7,170,744	31.00
43.00	04300 NURSERY		6,571,217	0	6,571,217	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		16,751,980	0	16,751,980	50.00
51.00	05100 RECOVERY ROOM		5,927,614	0	5,927,614	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		4,763,557	0	4,763,557	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,901,776	0	4,901,776	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC		1,620,000	0	1,620,000	55.00
57.00	05700 CT SCAN		2,375,749	0	2,375,749	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		1,216,096	0	1,216,096	58.00
59.00	05900 CARDIAC CATHETERIZATION		5,363,500	0	5,363,500	59.00
60.00	06000 LABORATORY		7,652,627	0	7,652,627	60.00
64.00	06400 INTRAVENOUS THERAPY		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	3,873,721	0	3,873,721	65.00
66.00	06600 PHYSICAL THERAPY	0	3,095,584	0	3,095,584	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	875,907	0	875,907	67.00
68.00	06800 SPEECH PATHOLOGY	0	207,568	0	207,568	68.00
69.00	06900 ELECTROCARDIOLOGY		2,235,793	0	2,235,793	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		1,481,103	0	1,481,103	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		12,050,893	0	12,050,893	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		13,336,561	0	13,336,561	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		16,044,812	0	16,044,812	73.00
74.00	07400 RENAL DIALYSIS		601,878	0	601,878	74.00
76.00	03950 ENDOSCOPY		1,936,877	0	1,936,877	76.00
76.06	03330 IMAGING CENTER		2,681,593	0	2,681,593	76.06
76.97	07697 CARDIAC REHABILITATION		381,459	0	381,459	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC		0	0	0	90.00
90.01	04950 DIABETIC CARE CENTER		0	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC		661,218	0	661,218	90.02
90.03	04952 PALLIATIVE CARE		0	0	0	90.03
90.04	04953 SPINE CENTER		236,921	0	236,921	90.04
91.00	09100 EMERGENCY		14,262,858	0	14,262,858	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		6,833,856	0	6,833,856	92.00
200.00	Subtotal (see instructions)		198,267,416	0	198,267,416	200.00
201.00	Less Observation Beds		6,833,856	0	6,833,856	201.00
202.00	Total (see instructions)		191,433,560	0	191,433,560	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/30/2017 10:50 am
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
9.00	10.00					
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	78,283,210		78,283,210	30.00
31.00	03100	INTENSIVE CARE UNIT	8,184,315		8,184,315	31.00
43.00	04300	NURSERY	14,525,016		14,525,016	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	56,791,595	30,930,160	87,721,755	50.00
51.00	05100	RECOVERY ROOM	12,232,190	16,811,625	29,043,815	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,330,424	0	10,330,424	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,236,372	23,766,579	32,002,951	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,398,552	11,099,868	18,498,420	55.00
57.00	05700	CT SCAN	13,410,464	37,383,340	50,793,804	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,284,251	8,494,754	10,779,005	58.00
59.00	05900	CARDIAC CATHETERIZATION	21,851,758	23,668,817	45,520,575	59.00
60.00	06000	LABORATORY	37,220,603	31,239,316	68,459,919	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	11,336,131	1,422,667	12,758,798	65.00
66.00	06600	PHYSICAL THERAPY	3,406,364	4,817,384	8,223,748	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,171,497	621,325	2,792,822	67.00
68.00	06800	SPEECH PATHOLOGY	509,516	157,245	666,761	68.00
69.00	06900	ELECTROCARDIOLOGY	6,378,645	11,955,361	18,334,006	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	229,064	4,801,395	5,030,459	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,401,261	13,984,147	35,385,408	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,401,192	10,943,623	37,344,815	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,963,515	21,678,148	63,641,663	73.00
74.00	07400	RENAL DIALYSIS	1,156,599	0	1,156,599	74.00
76.00	03950	ENDOSCOPY	2,102,827	8,236,998	10,339,825	76.00
76.06	03330	IMAGING CENTER	181,086	12,820,455	13,001,541	76.06
76.97	07697	CARDIAC REHABILITATION	2,580	1,114,725	1,117,305	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	12,278	1,439,636	1,451,914	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	90.03
90.04	04953	SPINE CENTER	148	423,602	423,750	90.04
91.00	09100	EMERGENCY	21,623,873	92,600,479	114,224,352	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,190,119	5,199,228	6,389,347	92.00
200.00		Subtotal (see instructions)	410,815,445	375,610,877	786,426,322	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	410,815,445	375,610,877	786,426,322	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/30/2017 10:50 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.190967		50.00
51.00	05100 RECOVERY ROOM	0.204092		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.461119		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.153166		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.087575		55.00
57.00	05700 CT SCAN	0.046772		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.112821		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.117826		59.00
60.00	06000 LABORATORY	0.111783		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.303612		65.00
66.00	06600 PHYSICAL THERAPY	0.376420		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.313628		67.00
68.00	06800 SPEECH PATHOLOGY	0.311308		68.00
69.00	06900 ELECTROCARDIOLOGY	0.121948		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.294427		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.340561		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.357119		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.252112		73.00
74.00	07400 RENAL DIALYSIS	0.520386		74.00
76.00	03950 ENDOSCOPY	0.187322		76.00
76.06	03330 IMAGING CENTER	0.206252		76.06
76.97	07697 CARDIAC REHABILITATION	0.341410		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
90.01	04950 DIABETIC CARE CENTER	0.000000		90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.455411		90.02
90.03	04952 PALLIATIVE CARE	0.000000		90.03
90.04	04953 SPINE CENTER	0.559106		90.04
91.00	09100 EMERGENCY	0.124867		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.069570		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2017 10:50 am

		Title XIX		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	53,153,954		53,153,954	0	53,153,954	30.00
31.00	03100 INTENSIVE CARE UNIT	7,170,744		7,170,744	0	7,170,744	31.00
43.00	04300 NURSERY	6,571,217		6,571,217	0	6,571,217	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	16,751,980		16,751,980	0	16,751,980	50.00
51.00	05100 RECOVERY ROOM	5,927,614		5,927,614	0	5,927,614	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,763,557		4,763,557	0	4,763,557	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,901,776		4,901,776	0	4,901,776	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	1,620,000		1,620,000	0	1,620,000	55.00
57.00	05700 CT SCAN	2,375,749		2,375,749	0	2,375,749	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,216,096		1,216,096	0	1,216,096	58.00
59.00	05900 CARDIAC CATHETERIZATION	5,363,500		5,363,500	0	5,363,500	59.00
60.00	06000 LABORATORY	7,652,627		7,652,627	0	7,652,627	60.00
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	3,873,721	0	3,873,721	0	3,873,721	65.00
66.00	06600 PHYSICAL THERAPY	3,095,584	0	3,095,584	0	3,095,584	66.00
67.00	06700 OCCUPATIONAL THERAPY	875,907	0	875,907	0	875,907	67.00
68.00	06800 SPEECH PATHOLOGY	207,568	0	207,568	0	207,568	68.00
69.00	06900 ELECTROCARDIOLOGY	2,235,793		2,235,793	0	2,235,793	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,481,103		1,481,103	0	1,481,103	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12,050,893		12,050,893	0	12,050,893	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	13,336,561		13,336,561	0	13,336,561	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	16,044,812		16,044,812	0	16,044,812	73.00
74.00	07400 RENAL DIALYSIS	601,878		601,878	0	601,878	74.00
76.00	03950 ENDOSCOPY	1,936,877		1,936,877	0	1,936,877	76.00
76.06	03330 IMAGING CENTER	2,681,593		2,681,593	0	2,681,593	76.06
76.97	07697 CARDIAC REHABILITATION	381,459		381,459	0	381,459	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0		0	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0		0	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	661,218		661,218	0	661,218	90.02
90.03	04952 PALLIATIVE CARE	0		0	0	0	90.03
90.04	04953 SPINE CENTER	236,921		236,921	0	236,921	90.04
91.00	09100 EMERGENCY	14,262,858		14,262,858	0	14,262,858	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6,833,856		6,833,856	0	6,833,856	92.00
200.00	Subtotal (see instructions)	198,267,416	0	198,267,416	0	198,267,416	200.00
201.00	Less Observation Beds	6,833,856		6,833,856	0	6,833,856	201.00
202.00	Total (see instructions)	191,433,560	0	191,433,560	0	191,433,560	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2017 10:50 am

		Title XIX			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	78,283,210		78,283,210		30.00
31.00	03100	INTENSIVE CARE UNIT	8,184,315		8,184,315		31.00
43.00	04300	NURSERY	14,525,016		14,525,016		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	56,791,595	30,930,160	87,721,755	0.190967	50.00
51.00	05100	RECOVERY ROOM	12,232,190	16,811,625	29,043,815	0.204092	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,330,424	0	10,330,424	0.461119	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,236,372	23,766,579	32,002,951	0.153166	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,398,552	11,099,868	18,498,420	0.087575	55.00
57.00	05700	CT SCAN	13,410,464	37,383,340	50,793,804	0.046772	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,284,251	8,494,754	10,779,005	0.112821	58.00
59.00	05900	CARDIAC CATHETERIZATION	21,851,758	23,668,817	45,520,575	0.117826	59.00
60.00	06000	LABORATORY	37,220,603	31,239,316	68,459,919	0.111783	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	11,336,131	1,422,667	12,758,798	0.303612	65.00
66.00	06600	PHYSICAL THERAPY	3,406,364	4,817,384	8,223,748	0.376420	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,171,497	621,325	2,792,822	0.313628	67.00
68.00	06800	SPEECH PATHOLOGY	509,516	157,245	666,761	0.311308	68.00
69.00	06900	ELECTROCARDIOLOGY	6,378,645	11,955,361	18,334,006	0.121948	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	229,064	4,801,395	5,030,459	0.294427	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,401,261	13,984,147	35,385,408	0.340561	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,401,192	10,943,623	37,344,815	0.357119	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,963,515	21,678,148	63,641,663	0.252112	73.00
74.00	07400	RENAL DIALYSIS	1,156,599	0	1,156,599	0.520386	74.00
76.00	03950	ENDOSCOPY	2,102,827	8,236,998	10,339,825	0.187322	76.00
76.06	03330	IMAGING CENTER	181,086	12,820,455	13,001,541	0.206252	76.06
76.97	07697	CARDIAC REHABILITATION	2,580	1,114,725	1,117,305	0.341410	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0.000000	90.01
90.02	04951	ANTI-COAGULATION CLINIC	12,278	1,439,636	1,451,914	0.455411	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0.000000	90.03
90.04	04953	SPINE CENTER	148	423,602	423,750	0.559106	90.04
91.00	09100	EMERGENCY	21,623,873	92,600,479	114,224,352	0.124867	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,190,119	5,199,228	6,389,347	1.069570	92.00
200.00		Subtotal (see instructions)	410,815,445	375,610,877	786,426,322		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	410,815,445	375,610,877	786,426,322		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/30/2017 10:50 am
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.190967		50.00
51.00	05100 RECOVERY ROOM	0.204092		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.461119		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.153166		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.087575		55.00
57.00	05700 CT SCAN	0.046772		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.112821		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.117826		59.00
60.00	06000 LABORATORY	0.111783		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.303612		65.00
66.00	06600 PHYSICAL THERAPY	0.376420		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.313628		67.00
68.00	06800 SPEECH PATHOLOGY	0.311308		68.00
69.00	06900 ELECTROCARDIOLOGY	0.121948		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.294427		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.340561		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.357119		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.252112		73.00
74.00	07400 RENAL DIALYSIS	0.520386		74.00
76.00	03950 ENDOSCOPY	0.187322		76.00
76.06	03330 IMAGING CENTER	0.206252		76.06
76.97	07697 CARDIAC REHABILITATION	0.341410		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
90.01	04950 DIABETIC CARE CENTER	0.000000		90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.455411		90.02
90.03	04952 PALLIATIVE CARE	0.000000		90.03
90.04	04953 SPINE CENTER	0.559106		90.04
91.00	09100 EMERGENCY	0.124867		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.069570		92.00
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: 15-0128

Period: From 01/01/2016 To 12/31/2016

Worksheet C Part II Date/Time Prepared: 5/30/2017 10:50 am

Cost Center Description		Title XIX			Hospital	PPS		
		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	16,751,980	2,321,046	14,430,934	0	0	50.00
51.00	05100	RECOVERY ROOM	5,927,614	400,041	5,527,573	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,763,557	434,175	4,329,382	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,901,776	673,852	4,227,924	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,620,000	79,765	1,540,235	0	0	55.00
57.00	05700	CT SCAN	2,375,749	291,428	2,084,321	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,216,096	244,989	971,107	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,363,500	906,872	4,456,628	0	0	59.00
60.00	06000	LABORATORY	7,652,627	314,135	7,338,492	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,873,721	253,264	3,620,457	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,095,584	467,201	2,628,383	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	875,907	56,096	819,811	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	207,568	13,200	194,368	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,235,793	270,497	1,965,296	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,481,103	183,220	1,297,883	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,050,893	1,161,816	10,889,077	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,336,561	318,816	13,017,745	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,044,812	670,175	15,374,637	0	0	73.00
74.00	07400	RENAL DIALYSIS	601,878	45,684	556,194	0	0	74.00
76.00	03950	ENDOSCOPY	1,936,877	239,563	1,697,314	0	0	76.00
76.06	03330	IMAGING CENTER	2,681,593	467,822	2,213,771	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	381,459	13,202	368,257	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	661,218	26,767	634,451	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	236,921	5,672	231,249	0	0	90.04
91.00	09100	EMERGENCY	14,262,858	1,168,950	13,093,908	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,833,856	531,872	6,301,984	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	131,371,501	11,560,120	119,811,381	0	0	200.00
201.00		Less Observation Beds	6,833,856	531,872	6,301,984	0	0	201.00
202.00		Total (line 200 minus line 201)	124,537,645	11,028,248	113,509,397	0	0	202.00



CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part II Date/Time Prepared: 5/30/2017 10:50 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	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	16,751,980	87,721,755	0.190967	50.00
51.00	05100 RECOVERY ROOM	5,927,614	29,043,815	0.204092	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,763,557	10,330,424	0.461119	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,901,776	32,002,951	0.153166	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	1,620,000	18,498,420	0.087575	55.00
57.00	05700 CT SCAN	2,375,749	50,793,804	0.046772	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,216,096	10,779,005	0.112821	58.00
59.00	05900 CARDIAC CATHETERIZATION	5,363,500	45,520,575	0.117826	59.00
60.00	06000 LABORATORY	7,652,627	68,459,919	0.111783	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	3,873,721	12,758,798	0.303612	65.00
66.00	06600 PHYSICAL THERAPY	3,095,584	8,223,748	0.376420	66.00
67.00	06700 OCCUPATIONAL THERAPY	875,907	2,792,822	0.313628	67.00
68.00	06800 SPEECH PATHOLOGY	207,568	666,761	0.311308	68.00
69.00	06900 ELECTROCARDIOLOGY	2,235,793	18,334,006	0.121948	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,481,103	5,030,459	0.294427	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12,050,893	35,385,408	0.340561	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	13,336,561	37,344,815	0.357119	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	16,044,812	63,641,663	0.252112	73.00
74.00	07400 RENAL DIALYSIS	601,878	1,156,599	0.520386	74.00
76.00	03950 ENDOSCOPY	1,936,877	10,339,825	0.187322	76.00
76.06	03330 IMAGING CENTER	2,681,593	13,001,541	0.206252	76.06
76.97	07697 CARDIAC REHABILITATION	381,459	1,117,305	0.341410	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0	0	0.000000	90.00
90.01	04950 DIABETIC CARE CENTER	0	0	0.000000	90.01
90.02	04951 ANTI-COAGULATION CLINIC	661,218	1,451,914	0.455411	90.02
90.03	04952 PALLIATIVE CARE	0	0	0.000000	90.03
90.04	04953 SPINE CENTER	236,921	423,750	0.559106	90.04
91.00	09100 EMERGENCY	14,262,858	114,224,352	0.124867	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6,833,856	6,389,347	1.069570	92.00
200.00	Subtotal (sum of lines 50 thru 199)	131,371,501	685,433,781		200.00
201.00	Less Observation Beds	6,833,856	0		201.00
202.00	Total (line 200 minus line 201)	124,537,645	685,433,781		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0128		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part I Date/Time Prepared: 5/30/2017 10:50 am	
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	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	4,136,901	0	4,136,901	35,289	117.23	30.00
31.00	INTENSIVE CARE UNIT	1,106,044		1,106,044	2,464	448.88	31.00
43.00	NURSERY	594,628		594,628	4,973	119.57	43.00
200.00	Total (Lines 30-199)	5,837,573		5,837,573	42,726		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	12,526	1,468,423				
31.00	INTENSIVE CARE UNIT	1,011	453,818				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	13,537	1,922,241				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Prepared: 5/30/2017 10:50 am
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Cost Center Description		Title XVIII			Hospital	PPS		
		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	2,321,046	87,721,755	0.026459	22,080,181	584,220	50.00
51.00	05100	RECOVERY ROOM	400,041	29,043,815	0.013774	3,890,304	53,585	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	434,175	10,330,424	0.042029	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	673,852	32,002,951	0.021056	3,714,264	78,208	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	79,765	18,498,420	0.004312	3,582,362	15,447	55.00
57.00	05700	CT SCAN	291,428	50,793,804	0.005737	5,709,424	32,755	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	244,989	10,779,005	0.022728	1,005,146	22,845	58.00
59.00	05900	CARDIAC CATHETERIZATION	906,872	45,520,575	0.019922	8,066,523	160,701	59.00
60.00	06000	LABORATORY	314,135	68,459,919	0.004589	15,667,639	71,899	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	253,264	12,758,798	0.019850	4,268,561	84,731	65.00
66.00	06600	PHYSICAL THERAPY	467,201	8,223,748	0.056811	1,691,917	96,119	66.00
67.00	06700	OCCUPATIONAL THERAPY	56,096	2,792,822	0.020086	1,146,175	23,022	67.00
68.00	06800	SPEECH PATHOLOGY	13,200	666,761	0.019797	282,636	5,595	68.00
69.00	06900	ELECTROCARDIOLOGY	270,497	18,334,006	0.014754	3,337,760	49,245	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	183,220	5,030,459	0.036422	86,854	3,163	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,161,816	35,385,408	0.032833	7,599,641	249,519	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	318,816	37,344,815	0.008537	10,482,677	89,491	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	670,175	63,641,663	0.010530	15,166,159	159,700	73.00
74.00	07400	RENAL DIALYSIS	45,684	1,156,599	0.039499	651,418	25,730	74.00
76.00	03950	ENDOSCOPY	239,563	10,339,825	0.023169	109,631	2,540	76.00
76.06	03330	IMAGING CENTER	467,822	13,001,541	0.035982	17,127	616	76.06
76.97	07697	CARDIAC REHABILITATION	13,202	1,117,305	0.011816	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0.000000	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	26,767	1,451,914	0.018436	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0.000000	0	0	90.03
90.04	04953	SPINE CENTER	5,672	423,750	0.013385	0	0	90.04
91.00	09100	EMERGENCY	1,168,950	114,224,352	0.010234	9,782,398	100,113	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	531,872	6,389,347	0.083244	555,736	46,262	92.00
200.00		Total (lines 50-199)	11,560,120	685,433,781		118,894,533	1,955,506	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-0128		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part III Date/Time Prepared: 5/30/2017 10:50 am	
Cost Center Description			Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	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	35,289	0.00	12,526	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,464	0.00	1,011	0		31.00
43.00	04300	NURSERY	4,973	0.00	0	0		43.00
200.00		Total (lines 30-199)	42,726		13,537	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/30/2017 10:50 am
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Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		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	
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00	
57.00	05700	CT SCAN	0	0	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00	
76.00	03950	ENDOSCOPY	0	0	0	0	0	76.00	
76.06	03330	IMAGING CENTER	0	0	0	0	0	76.06	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	90.00	
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	90.01	
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	0	0	90.02	
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	90.03	
90.04	04953	SPINE CENTER	0	0	0	0	0	90.04	
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
200.00		Total (lines 50-199)	0	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/30/2017 10:50 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XVIII			Hospital		Inpatient Program Charges	PPS
			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)				
		6.00	7.00	8.00	9.00	10.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	87,721,755	0.000000	0.000000	22,080,181	50.00	
51.00	05100	RECOVERY ROOM	0	29,043,815	0.000000	0.000000	3,890,304	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	10,330,424	0.000000	0.000000	0	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,002,951	0.000000	0.000000	3,714,264	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	18,498,420	0.000000	0.000000	3,582,362	55.00	
57.00	05700	CT SCAN	0	50,793,804	0.000000	0.000000	5,709,424	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	10,779,005	0.000000	0.000000	1,005,146	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	45,520,575	0.000000	0.000000	8,066,523	59.00	
60.00	06000	LABORATORY	0	68,459,919	0.000000	0.000000	15,667,639	60.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0	12,758,798	0.000000	0.000000	4,268,561	65.00	
66.00	06600	PHYSICAL THERAPY	0	8,223,748	0.000000	0.000000	1,691,917	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	2,792,822	0.000000	0.000000	1,146,175	67.00	
68.00	06800	SPEECH PATHOLOGY	0	666,761	0.000000	0.000000	282,636	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	18,334,006	0.000000	0.000000	3,337,760	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,030,459	0.000000	0.000000	86,854	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	35,385,408	0.000000	0.000000	7,599,641	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	37,344,815	0.000000	0.000000	10,482,677	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	63,641,663	0.000000	0.000000	15,166,159	73.00	
74.00	07400	RENAL DIALYSIS	0	1,156,599	0.000000	0.000000	651,418	74.00	
76.00	03950	ENDOSCOPY	0	10,339,825	0.000000	0.000000	109,631	76.00	
76.06	03330	IMAGING CENTER	0	13,001,541	0.000000	0.000000	17,127	76.06	
76.97	07697	CARDIAC REHABILITATION	0	1,117,305	0.000000	0.000000	0	76.97	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00	
90.01	04950	DIABETIC CARE CENTER	0	0	0.000000	0.000000	0	90.01	
90.02	04951	ANTI-COAGULATION CLINIC	0	1,451,914	0.000000	0.000000	0	90.02	
90.03	04952	PALLIATIVE CARE	0	0	0.000000	0.000000	0	90.03	
90.04	04953	SPINE CENTER	0	423,750	0.000000	0.000000	0	90.04	
91.00	09100	EMERGENCY	0	114,224,352	0.000000	0.000000	9,782,398	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	6,389,347	0.000000	0.000000	555,736	92.00	
200.00		Total (lines 50-199)	0	685,433,781			118,894,533	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/30/2017 10:50 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	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	6,245,769	0	50.00
51.00	05100 RECOVERY ROOM	0	3,769,757	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	5,592,914	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	5,496,904	0	55.00
57.00	05700 CT SCAN	0	8,617,694	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	2,246,426	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	9,819,538	0	59.00
60.00	06000 LABORATORY	0	5,913,832	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	204,273	0	65.00
66.00	06600 PHYSICAL THERAPY	0	45,987	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	31,274	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	2,307	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	3,807,471	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1,258,574	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,595,767	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	3,674,226	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4,545,938	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.00	03950 ENDOSCOPY	0	2,290,679	0	76.00
76.06	03330 IMAGING CENTER	0	2,825,692	0	76.06
76.97	07697 CARDIAC REHABILITATION	0	407,678	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	0	753,155	0	90.02
90.03	04952 PALLIATIVE CARE	0	0	0	90.03
90.04	04953 SPINE CENTER	0	0	0	90.04
91.00	09100 EMERGENCY	0	13,584,108	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,340,104	0	92.00
200.00	Total (lines 50-199)	0	87,070,067	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/30/2017 10:50 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.190967	6,245,769	0	0	1,192,736	50.00
51.00	05100	RECOVERY ROOM	0.204092	3,769,757	338	0	769,377	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.461119	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.153166	5,592,914	0	0	856,644	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.087575	5,496,904	0	0	481,391	55.00
57.00	05700	CT SCAN	0.046772	8,617,694	0	0	403,067	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.112821	2,246,426	0	0	253,444	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.117826	9,819,538	0	0	1,156,997	59.00
60.00	06000	LABORATORY	0.111783	5,913,832	0	0	661,066	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.303612	204,273	0	0	62,020	65.00
66.00	06600	PHYSICAL THERAPY	0.376420	45,987	0	0	17,310	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.313628	31,274	0	0	9,808	67.00
68.00	06800	SPEECH PATHOLOGY	0.311308	2,307	0	0	718	68.00
69.00	06900	ELECTROCARDIOLOGY	0.121948	3,807,471	0	0	464,313	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.294427	1,258,574	0	0	370,558	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.340561	3,595,767	0	0	1,224,578	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.357119	3,674,226	0	0	1,312,136	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252112	4,545,938	0	170,269	1,146,086	73.00
74.00	07400	RENAL DIALYSIS	0.520386	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0.187322	2,290,679	0	0	429,095	76.00
76.06	03330	IMAGING CENTER	0.206252	2,825,692	0	0	582,805	76.06
76.97	07697	CARDIAC REHABILITATION	0.341410	407,678	0	0	139,185	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0.455411	753,155	0	0	342,995	90.02
90.03	04952	PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953	SPIRE CENTER	0.559106	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.124867	13,584,108	0	141	1,696,207	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.069570	2,340,104	0	63	2,502,905	92.00
200.00		Subtotal (see instructions)		87,070,067	338	170,473	16,075,441	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		87,070,067	338	170,473	16,075,441	202.00



APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/30/2017 10:50 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	69	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	42,927	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	ENDOSCOPY	0	0	76.00
76.06	03330	IMAGING CENTER	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	90.03
90.04	04953	SPINE CENTER	0	0	90.04
91.00	09100	EMERGENCY	0	18	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	67	92.00
200.00		Subtotal (see instructions)	69	43,012	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	69	43,012	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0128		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part I Date/Time Prepared: 5/30/2017 10:50 am	
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	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	4,136,901	0	4,136,901	35,289	117.23	30.00
31.00	INTENSIVE CARE UNIT	1,106,044		1,106,044	2,464	448.88	31.00
43.00	NURSERY	594,628		594,628	4,973	119.57	43.00
200.00	Total (Lines 30-199)	5,837,573		5,837,573	42,726		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	702	82,295				
31.00	INTENSIVE CARE UNIT	0	0				
43.00	NURSERY	1,700	203,269				
200.00	Total (Lines 30-199)	2,402	285,564				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Prepared: 5/30/2017 10:50 am
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Cost Center Description		Title XIX			Hospital	PPS		
		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	2,321,046	87,721,755	0.026459	271,422	7,182	50.00
51.00	05100	RECOVERY ROOM	400,041	29,043,815	0.013774	125,458	1,728	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	434,175	10,330,424	0.042029	239,316	10,058	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	673,852	32,002,951	0.021056	108,257	2,279	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	79,765	18,498,420	0.004312	76,034	328	55.00
57.00	05700	CT SCAN	291,428	50,793,804	0.005737	203,817	1,169	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	244,989	10,779,005	0.022728	42,392	963	58.00
59.00	05900	CARDIAC CATHETERIZATION	906,872	45,520,575	0.019922	150,551	2,999	59.00
60.00	06000	LABORATORY	314,135	68,459,919	0.004589	760,390	3,489	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	253,264	12,758,798	0.019850	305,715	6,068	65.00
66.00	06600	PHYSICAL THERAPY	467,201	8,223,748	0.056811	30,453	1,730	66.00
67.00	06700	OCCUPATIONAL THERAPY	56,096	2,792,822	0.020086	18,492	371	67.00
68.00	06800	SPEECH PATHOLOGY	13,200	666,761	0.019797	12,365	245	68.00
69.00	06900	ELECTROCARDIOLOGY	270,497	18,334,006	0.014754	53,955	796	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	183,220	5,030,459	0.036422	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,161,816	35,385,408	0.032833	326,468	10,719	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	318,816	37,344,815	0.008537	41,033	350	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	670,175	63,641,663	0.010530	807,425	8,502	73.00
74.00	07400	RENAL DIALYSIS	45,684	1,156,599	0.039499	0	0	74.00
76.00	03950	ENDOSCOPY	239,563	10,339,825	0.023169	40,395	936	76.00
76.06	03330	IMAGING CENTER	467,822	13,001,541	0.035982	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	13,202	1,117,305	0.011816	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0.000000	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	26,767	1,451,914	0.018436	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0.000000	0	0	90.03
90.04	04953	SPINE CENTER	5,672	423,750	0.013385	0	0	90.04
91.00	09100	EMERGENCY	1,168,950	114,224,352	0.010234	381,665	3,906	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	531,872	6,389,347	0.083244	47,470	3,952	92.00
200.00		Total (lines 50-199)	11,560,120	685,433,781		4,043,073	67,770	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-0128		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part III Date/Time Prepared: 5/30/2017 10:50 am		
Cost Center Description			Title XIX			Hospital		PPS	
			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	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	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	35,289	0.00	702	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,464	0.00	0	0	0	0	31.00
43.00	04300	NURSERY	4,973	0.00	1,700	0	0	0	43.00
200.00		Total (lines 30-199)	42,726		2,402	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/30/2017 10:50 am
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Cost Center Description		Title XIX				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00	03950	ENDOSCOPY	0	0	0	0	0	0	76.00
76.06	03330	IMAGING CENTER	0	0	0	0	0	0	76.06
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0	0	0	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	0	0	0	0	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0	0	0	0	90.03
90.04	04953	SPINE CENTER	0	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/30/2017 10:50 am
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Cost Center Description		Title XIX			Hospital		PPS	
		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	87,721,755	0.000000	0.000000	271,422	50.00
51.00	05100	RECOVERY ROOM	0	29,043,815	0.000000	0.000000	125,458	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	10,330,424	0.000000	0.000000	239,316	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,002,951	0.000000	0.000000	108,257	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	18,498,420	0.000000	0.000000	76,034	55.00
57.00	05700	CT SCAN	0	50,793,804	0.000000	0.000000	203,817	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	10,779,005	0.000000	0.000000	42,392	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	45,520,575	0.000000	0.000000	150,551	59.00
60.00	06000	LABORATORY	0	68,459,919	0.000000	0.000000	760,390	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	12,758,798	0.000000	0.000000	305,715	65.00
66.00	06600	PHYSICAL THERAPY	0	8,223,748	0.000000	0.000000	30,453	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,792,822	0.000000	0.000000	18,492	67.00
68.00	06800	SPEECH PATHOLOGY	0	666,761	0.000000	0.000000	12,365	68.00
69.00	06900	ELECTROCARDIOLOGY	0	18,334,006	0.000000	0.000000	53,955	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,030,459	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	35,385,408	0.000000	0.000000	326,468	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	37,344,815	0.000000	0.000000	41,033	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	63,641,663	0.000000	0.000000	807,425	73.00
74.00	07400	RENAL DIALYSIS	0	1,156,599	0.000000	0.000000	0	74.00
76.00	03950	ENDOSCOPY	0	10,339,825	0.000000	0.000000	40,395	76.00
76.06	03330	IMAGING CENTER	0	13,001,541	0.000000	0.000000	0	76.06
76.97	07697	CARDIAC REHABILITATION	0	1,117,305	0.000000	0.000000	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	04950	DIABETIC CARE CENTER	0	0	0.000000	0.000000	0	90.01
90.02	04951	ANTI-COAGULATION CLINIC	0	1,451,914	0.000000	0.000000	0	90.02
90.03	04952	PALLIATIVE CARE	0	0	0.000000	0.000000	0	90.03
90.04	04953	SPINE CENTER	0	423,750	0.000000	0.000000	0	90.04
91.00	09100	EMERGENCY	0	114,224,352	0.000000	0.000000	381,665	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	6,389,347	0.000000	0.000000	47,470	92.00
200.00		Total (lines 50-199)	0	685,433,781			4,043,073	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/30/2017 10:50 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	PPS
		11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0		55.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	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
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
76.00	03950 ENDOSCOPY	0	0	0		76.00
76.06	03330 IMAGING CENTER	0	0	0		76.06
76.97	07697 CARDIAC REHABILITATION	0	0	0		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0	0	0		90.00
90.01	04950 DIABETIC CARE CENTER	0	0	0		90.01
90.02	04951 ANTI-COAGULATION CLINIC	0	0	0		90.02
90.03	04952 PALLIATIVE CARE	0	0	0		90.03
90.04	04953 SPINE CENTER	0	0	0		90.04
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/30/2017 10:50 am
		Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.190967	0	267,345	0	0	50.00
51.00	05100 RECOVERY ROOM	0.204092	0	73,176	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.461119	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.153166	0	468,761	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.087575	0	101,318	0	0	55.00
57.00	05700 CT SCAN	0.046772	0	490,083	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.112821	0	52,607	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.117826	0	74,661	0	0	59.00
60.00	06000 LABORATORY	0.111783	0	678,971	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.303612	0	31,468	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.376420	0	34,973	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.313628	0	3,318	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.311308	0	6,625	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.121948	0	111,747	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.294427	0	16,194	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.340561	0	146,637	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.357119	0	70,255	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.252112	0	170,159	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.520386	0	0	0	0	74.00
76.00	03950 ENDOSCOPY	0.187322	0	63,903	0	0	76.00
76.06	03330 IMAGING CENTER	0.206252	0	93,240	0	0	76.06
76.97	07697 CARDIAC REHABILITATION	0.341410	0	3,079	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0.000000	0	0	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.455411	0	3,166	0	0	90.02
90.03	04952 PALLIATIVE CARE	0.000000	0	0	0	0	90.03
90.04	04953 SPINE CENTER	0.559106	0	0	0	0	90.04
91.00	09100 EMERGENCY	0.124867	0	2,405,111	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.069570	0	243,956	0	0	92.00
200.00	Subtotal (see instructions)		0	5,610,753	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	5,610,753	0	0	202.00



APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/30/2017 10:50 am
		Title XIX	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	51,054	0	50.00
51.00	05100 RECOVERY ROOM	14,935	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	71,798	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	8,873	0	55.00
57.00	05700 CT SCAN	22,922	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	5,935	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	8,797	0	59.00
60.00	06000 LABORATORY	75,897	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	9,554	0	65.00
66.00	06600 PHYSICAL THERAPY	13,165	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,041	0	67.00
68.00	06800 SPEECH PATHOLOGY	2,062	0	68.00
69.00	06900 ELECTROCARDIOLOGY	13,627	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	4,768	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	49,939	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	25,089	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	42,899	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03950 ENDOSCOPY	11,970	0	76.00
76.06	03330 IMAGING CENTER	19,231	0	76.06
76.97	07697 CARDIAC REHABILITATION	1,051	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	1,442	0	90.02
90.03	04952 PALLIATIVE CARE	0	0	90.03
90.04	04953 SPINE CENTER	0	0	90.04
91.00	09100 EMERGENCY	300,319	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	260,928	0	92.00
200.00	Subtotal (see instructions)	1,017,296	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)	1,017,296	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/30/2017 10:50 am
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		35,289	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		35,289	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)		30,752	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)		12,526	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
<b>SWING BED ADJUSTMENT</b>				
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)		53,153,954	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)		53,153,954	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		53,153,954	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,506.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		18,867,288	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)		18,867,288	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1	
Date/Time Prepared: 5/30/2017 10:50 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)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	7,170,744	2,464	2,910.20	1,011	2,942,212		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)					24,122,607		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					45,932,107		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)					1,922,241		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,955,506		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					3,877,747		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					42,054,360		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)					4,537		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,506.25		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					6,833,856		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/30/2017 10:50 am	
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	4,136,901	53,153,954	0.077829	6,833,856	531,872	90.00
91.00	Nursing School cost	0	53,153,954	0.000000	6,833,856	0	91.00
92.00	Allied health cost	0	53,153,954	0.000000	6,833,856	0	92.00
93.00	All other Medical Education	0	53,153,954	0.000000	6,833,856	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/30/2017 10:50 am
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		35,289	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		35,289	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)		30,752	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)		702	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)		4,973	15.00
16.00	Nursery days (title V or XIX only)		1,700	16.00
<b>SWING BED ADJUSTMENT</b>				
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)		53,153,954	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)		53,153,954	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		53,153,954	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,506.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,057,388	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)		1,057,388	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/30/2017 10:50 am		
Cost Center Description			Title XIX		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00	NURSERY (title V & XIX only)	6,571,217	4,973	1,321.38	1,700	2,246,346	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	7,170,744	2,464	2,910.20	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					883,990	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,187,724	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)					285,564	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					67,770	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					353,334	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,834,390	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)					4,537	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,506.25	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					6,833,856	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0128		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/30/2017 10:50 am	
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	4,136,901	53,153,954	0.077829	6,833,856	531,872	90.00
91.00	Nursing School cost	0	53,153,954	0.000000	6,833,856	0	91.00
92.00	Allied health cost	0	53,153,954	0.000000	6,833,856	0	92.00
93.00	All other Medical Education	0	53,153,954	0.000000	6,833,856	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/30/2017 10:50 am	
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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		23,165,214		30.00
31.00	03100 INTENSIVE CARE UNIT		3,256,852		31.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.190967	22,080,181	4,216,586	50.00
51.00	05100 RECOVERY ROOM	0.204092	3,890,304	793,980	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.461119	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.153166	3,714,264	568,899	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.087575	3,582,362	313,725	55.00
57.00	05700 CT SCAN	0.046772	5,709,424	267,041	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.112821	1,005,146	113,402	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.117826	8,066,523	950,446	59.00
60.00	06000 LABORATORY	0.111783	15,667,639	1,751,376	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.303612	4,268,561	1,295,986	65.00
66.00	06600 PHYSICAL THERAPY	0.376420	1,691,917	636,871	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.313628	1,146,175	359,473	67.00
68.00	06800 SPEECH PATHOLOGY	0.311308	282,636	87,987	68.00
69.00	06900 ELECTROCARDIOLOGY	0.121948	3,337,760	407,033	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.294427	86,854	25,572	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.340561	7,599,641	2,588,141	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.357119	10,482,677	3,743,563	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.252112	15,166,159	3,823,571	73.00
74.00	07400 RENAL DIALYSIS	0.520386	651,418	338,989	74.00
76.00	03950 ENDOSCOPY	0.187322	109,631	20,536	76.00
76.06	03330 IMAGING CENTER	0.206252	17,127	3,532	76.06
76.97	07697 CARDIAC REHABILITATION	0.341410	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0.000000	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.455411	0	0	90.02
90.03	04952 PALLIATIVE CARE	0.000000	0	0	90.03
90.04	04953 SPINE CENTER	0.559106	0	0	90.04
91.00	09100 EMERGENCY	0.124867	9,782,398	1,221,499	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.069570	555,736	594,399	92.00
200.00	Total (sum of lines 50-94 and 96-98)		118,894,533	24,122,607	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)		118,894,533		202.00



INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/30/2017 10:50 am
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		2,558,872		30.00
31.00	03100 INTENSIVE CARE UNIT		250,472		31.00
43.00	04300 NURSERY		202,837		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.190967	271,422	51,833	50.00
51.00	05100 RECOVERY ROOM	0.204092	125,458	25,605	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.461119	239,316	110,353	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.153166	108,257	16,581	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.087575	76,034	6,659	55.00
57.00	05700 CT SCAN	0.046772	203,817	9,533	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.112821	42,392	4,783	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.117826	150,551	17,739	59.00
60.00	06000 LABORATORY	0.111783	760,390	84,999	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.303612	305,715	92,819	65.00
66.00	06600 PHYSICAL THERAPY	0.376420	30,453	11,463	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.313628	18,492	5,800	67.00
68.00	06800 SPEECH PATHOLOGY	0.311308	12,365	3,849	68.00
69.00	06900 ELECTROCARDIOLOGY	0.121948	53,955	6,580	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.294427	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.340561	326,468	111,182	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.357119	41,033	14,654	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.252112	807,425	203,562	73.00
74.00	07400 RENAL DIALYSIS	0.520386	0	0	74.00
76.00	03950 ENDOSCOPY	0.187322	40,395	7,567	76.00
76.06	03330 IMAGING CENTER	0.206252	0	0	76.06
76.97	07697 CARDIAC REHABILITATION	0.341410	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0.000000	0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	0.455411	0	0	90.02
90.03	04952 PALLIATIVE CARE	0.000000	0	0	90.03
90.04	04953 SPINE CENTER	0.559106	0	0	90.04
91.00	09100 EMERGENCY	0.124867	381,665	47,657	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.069570	47,470	50,772	92.00
200.00	Total (sum of lines 50-94 and 96-98)		4,043,073	883,990	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		4,043,073		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/30/2017 10:50 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
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)		20,502,880	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		7,285,071	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)		334,723	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		9,961,445	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		156.78	4.00
<b>Indirect Medical Education Adjustment</b>				
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).		2.72	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)		2.72	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		5.48	10.00
11.00	FTE count for residents in dental and podiatric programs.		1.08	11.00
12.00	Current year allowable FTE (see instructions)		3.80	12.00
13.00	Total allowable FTE count for the prior year.		0.45	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.		0.18	14.00
15.00	Sum of lines 12 through 14 divided by 3.		1.48	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		1.48	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.009440	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.002874	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.002874	21.00
22.00	IME payment adjustment (see instructions)		43,627	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		15,639	22.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
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)		2.76	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)		43,627	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		15,639	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.26	30.00
31.00	Percentage of Medicaid patient days (see instructions)		19.92	31.00
32.00	Sum of lines 30 and 31		22.18	32.00
33.00	Allowable disproportionate share percentage (see instructions)		7.51	33.00
34.00	Disproportionate share adjustment (see instructions)		521,719	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/30/2017 10:50 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
<b>Uncompensated Care Adjustment</b>				
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000136849	0.000144967	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	876,675	866,536	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	656,309	218,415	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	874,724		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>				
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 and 685. (see instructions)		0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 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 and 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)	29,562,744		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
				<b>Amount</b>
				<b>1.00</b>
49.00	Total payment for inpatient operating costs (see instructions)		29,578,383	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,430,145	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).		114,238	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 instructions)		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)		32,122,766	59.00
60.00	Primary payer payments		4,959	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		32,117,807	61.00
62.00	Deductibles billed to program beneficiaries		3,153,136	62.00
63.00	Coinurance billed to program beneficiaries		86,198	63.00
64.00	Allowable bad debts (see instructions)		150,339	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		97,720	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		66,490	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		28,976,193	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)		-83,869	70.93
70.94	HRR adjustment amount (see instructions)		-279,494	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/30/2017 10:50 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)	0		0	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)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			28,612,830	71.00
71.01	Sequestration adjustment (see instructions)			572,257	71.01
72.00	Interim payments			27,971,270	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)			69,303	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			5,341,174	75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>					
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	
<b>HSP Bonus Payment Amount</b>					
100.00	HSP bonus amount (see instructions)			0	100.00
<b>HVBP Adjustment for HSP Bonus Payment</b>					
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	102.00
<b>HRR Adjustment for HSP Bonus Payment</b>					
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	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/30/2017 10:50 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		43,081	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		16,075,441	2.00
3.00	PPS payments		12,731,741	3.00
4.00	Outlier payment (see instructions)		19,415	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)		43,081	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		170,811	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)		170,811	14.00
<b>Customary charges</b>				
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 charge basis 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)		170,811	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		127,730	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)		43,081	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)		12,751,156	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		85	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,416,455	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)		10,377,697	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		40,084	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)		10,417,781	30.00
31.00	Primary payer payments		3,574	31.00
32.00	Subtotal (line 30 minus line 31)		10,414,207	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		292,900	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		190,385	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		252,228	36.00
37.00	Subtotal (see instructions)		10,604,592	37.00
38.00	MSP-LCC reconciliation amount from PS&R		95	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)		10,604,497	40.00
40.01	Sequestration adjustment (see instructions)		212,090	40.01
41.00	Interim payments		10,356,240	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		36,167	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/30/2017 10:50 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		27,872,970		10,320,040	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	07/01/2016	98,300	07/01/2016	36,200	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)		98,300		36,200	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)		27,971,270		10,356,240	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		69,303		36,167	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		28,040,573		10,392,407	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: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/30/2017 10:50 am
		Title XVIII	Hospital	PPS
		1.00		
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		9,545	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		13,537	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		4,899	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		33,216	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		786,426,322	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		1,261,987	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
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0128		Period: From 01/01/2016 To 12/31/2016		Worksheet E-4 Date/Time Prepared: 5/30/2017 10:50 am	
		Title XVIII		Hospital		PPS	
						1.00	
<b>COMPUTATION OF TOTAL DIRECT GME AMOUNT</b>							
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.					0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)					0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA					0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)					0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					2.71	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)					0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)					0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)					2.71	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					6.56	6.00
7.00	Enter the lesser of line 5 or line 6					2.71	7.00
		Primary Care	Other			Total	
		1.00	2.00			3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	5.15	0.33			5.48	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	2.13	0.14			2.27	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		1.08				10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00				10.01
11.00	Total weighted FTE count	2.13	1.22				11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	3.83	0.80				12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	1.84	0.42				13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	2.60	0.81				14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00				15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00				15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00				16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00				16.01
17.00	Adjusted rolling average FTE count	2.60	0.81				17.00
18.00	Per resident amount	86,332.87	86,332.87				18.00
19.00	Approved amount for resident costs	224,465	69,930			294,395	19.00
						1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)					0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)					3.85	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)					0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)					0.00	23.00
24.00	Multiply line 22 time line 23					0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)					294,395	25.00
		Inpatient Part A	Managed care				
		1.00	2.00			3.00	
<b>COMPUTATION OF PROGRAM PATIENT LOAD</b>							
26.00	Inpatient Days (see instructions)	13,537	4,899				26.00
27.00	Total Inpatient Days (see instructions)	33,849	33,849				27.00
28.00	Ratio of inpatient days to total inpatient days	0.399923	0.144731				28.00
29.00	Program direct GME amount	117,735	42,608				29.00
30.00	Reduction for direct GME payments for Medicare Advantage		6,021				30.00
31.00	Net Program direct GME amount					154,322	31.00



DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet E-4 Date/Time Prepared: 5/30/2017 10:50 am
		Title XVIII	Hospital	PPS
				1.00
<b>DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)</b>				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		1,156,599	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
<b>APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY</b>				
<b>Part A Reasonable Cost</b>				
37.00	Reasonable cost (see instructions)		45,932,107	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		4,959	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		45,927,148	41.00
<b>Part B Reasonable Cost</b>				
42.00	Reasonable cost (see instructions)		16,118,522	42.00
43.00	Primary payer payments (see instructions)		3,574	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		16,114,948	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		62,042,096	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.740258	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.259742	47.00
<b>ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B</b>				
48.00	Total program GME payment (line 31)		154,322	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		114,238	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		40,084	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet G

Date/Time Prepared:  
5/30/2017 10:50 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	3,374	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	167,066,669	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-134,304,582	0	0	0	6.00
7.00	Inventory	3,060,404	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	82,182	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)	35,908,047	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	497,000	0	0	0	12.00
13.00	Land improvements	2,722,362	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	172,256,761	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	1,782,184	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	68,340,731	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	115,657	0	0	0	23.00
24.00	Accumulated depreciation	-112,012,679	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)	133,702,016	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	243,118,912	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	243,118,912	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	412,728,975	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	185,475	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	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	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,420,474	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,605,949	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	1,605,949	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	411,123,026	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	411,123,026	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	412,728,975	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet G-1

Date/Time Prepared:  
5/30/2017 10:50 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		378,822,252		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		32,300,775				2.00
3.00	Total (sum of line 1 and line 2)		411,123,027		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		411,123,027		0		11.00
12.00	ROUNDING	1		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)		1		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		411,123,026		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	ROUNDING		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: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/30/2017 10:50 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	92,339,939		92,339,939	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	92,339,939		92,339,939	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	8,681,632		8,681,632	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)	8,681,632		8,681,632	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	101,021,571		101,021,571	17.00
18.00	Ancillary services	298,770,522	399,264,938	698,035,460	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				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	0	95,470	95,470	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	399,792,093	399,360,408	799,152,501	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		207,552,705		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)		207,552,705		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0128

Period:  
From 01/01/2016  
To 12/31/2016

Worksheet G-3

Date/Time Prepared:  
5/30/2017 10:50 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	799,152,501	1.00
2.00	Less contractual allowances and discounts on patients' accounts	561,291,134	2.00
3.00	Net patient revenues (line 1 minus line 2)	237,861,367	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	207,552,705	4.00
5.00	Net income from service to patients (line 3 minus line 4)	30,308,662	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	99,834	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	5,018	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC REVENUE	1,887,261	24.00
25.00	Total other income (sum of lines 6-24)	1,992,113	25.00
26.00	Total (line 5 plus line 25)	32,300,775	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	32,300,775	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0128	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 5/30/2017 10:50 am
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		2,234,096	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		83,451	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)		93.84	3.00
4.00	Number of interns & residents (see instructions)		1.48	4.00
5.00	Indirect medical education percentage (see instructions)		0.45	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)		10,053	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		2.26	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		19.92	8.00
9.00	Sum of lines 7 and 8		22.18	9.00
10.00	Allowable disproportionate share percentage (see instructions)		4.59	10.00
11.00	Disproportionate share adjustment (see instructions)		102,545	11.00
12.00	Total prospective capital payments (see instructions)		2,430,145	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
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
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
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