

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: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 3/31/2017 12:54 pm
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**PART I - COST REPORT STATUS**

Provider use only

1.  Electronically filed cost report  
 2.  Manually submitted cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5.  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.  Initial Report for this Provider CCN  
 9.  Final Report for this Provider CCN

10. NPR Date:  
 11. Contractor's Vendor Code: 4  
 12.  If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 3/31/2017 Time: 12:54 pm

**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 FRANCSAN HEALTH MICHIGAN CITY ( 15-0015 ) 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	130,280	-23,723	478,290	0	1.00
2.00 Subprovider - IPF	0	12,613	0		0	2.00
3.00 Subprovider - IRF	0	24,278	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
200.00 Total	0	167,171	-23,723	478,290	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: 15-0015		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 3/31/2017 12:53 pm			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00 Street: 301 W. HOMER ST		PO Box:		Zip Code: 46360		County: LAPORTE					
2.00 City: MICHIGAN CITY		State: IN									
		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		FRANCISCAN HEALTH MICHIGAN CITY		150015	33140	1	07/01/1966	N	P	0	3.00
4.00 Subprovider - IPF		FRANCISCAN HEALTH MICHIGAN CITY		15S015	33140	4	01/01/1998	N	P	0	4.00
5.00 Subprovider - IRF		FRANCISCAN HEALTH MICHIGAN CITY		15T015	33140	5	01/01/1997	N	P	0	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)							1			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.								1		N	23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.				3,373	151	48	54	1,455	71	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.				115	15	0	0	60		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0015		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 3/31/2017 12:53 pm			
		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.		0				36.00		
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.		0				37.00		
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)		N				37.01		
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.						38.00		
		Y/N		Y/N					
		1.00		2.00					
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)		N	N			39.00		
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)		N	N			40.00		
		V	XVII	XIX					
		1.00	2.00	3.00					
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)		N	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		
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.		N				56.00		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.						57.00		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.		N				58.00		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.		N				59.00		
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)		N				60.00		
		Y/N	IME	Direct GME	IME	Direct GME			
		1.00	2.00	3.00	4.00	5.00			
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)			0.00	0.00				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)			0.00	0.00				61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)			0.00	0.00				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).			0.00	0.00				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)			0.00	0.00				61.05

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	Y/N	IME	Direct GME	IME	Direct GME		
	1.00	2.00	3.00	4.00	5.00		
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	0.00	0.00				61.06
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00	2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.		0.00	0.00		61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.		0.00	0.00		61.20	
						1.00	
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
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)					N	63.00
	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))				
	1.00	2.00	3.00				
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	0.00	0.000000		66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 67.00	
				1.00	2.00	3.00	
<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.			Y			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)			N		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.			Y			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)			N		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.			N		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	Y		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)	N				106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	N				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical		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.	N		N		N	
						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	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y				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.	2				118.00	
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	706,967		3,000		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: 15-0015		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 3/31/2017 12:53 pm	
		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	15H014			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: FRANCISCAN ALLIANCE, INC	Contractor's Name: WPS		Contractor's Number: 8001		141.00	
142.00	Street: 1515 DRAGOON TRAIL	PO Box:				142.00	
143.00	City: MISHAWAKA	State: IN	Zip Code: 46546			143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
						1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
						1.00	
165.00	Multi campus 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	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			0		168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.25		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 3/31/2017 12:53 pm
		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)	01/01/2016	12/31/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 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: 15-0015		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part II Date/Time Prepared: 3/31/2017 12:53 pm	
		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)	N					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.	N	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					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	03/16/2017	Y	03/16/2017		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 3/31/2017 12:53 pm	
		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		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			Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			Y	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.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<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.				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.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
<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.	MATTHEW		DEETS	41.00
42.00	Enter the employer/company name of the cost report preparer.	FRANCSAN ALLIANCE INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(219) 932-2300 X33148		MATTHEW.DEETS@FRANCSANALLIANCE.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 15-0015

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
3/31/2017 12:53 pm

		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.	SR. FINANCIAL ANALYST	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: 15-0015

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
3/31/2017 12:53 pm

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	135	49,410	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)		135	49,410	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	14	5,124	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)		149	54,534	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	18	6,588		0	16.00
17.00 SUBPROVIDER - IRF	41.00	16	5,856		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY	45.00	0	0		0	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)		183				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: 15-0015

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
3/31/2017 12:53 pm

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)	10,053	2,966	17,260			1.00
2.00 HMO and other (see instructions)	1,673	0				2.00
3.00 HMO IPF Subprovider	14	0				3.00
4.00 HMO IRF Subprovider	200	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)	10,053	2,966	17,260			7.00
8.00 INTENSIVE CARE UNIT	1,456	679	2,995			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		797	1,102			13.00
14.00 Total (see instructions)	11,509	4,442	21,357	0.00	693.25	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	986	1,347	3,164	0.00	17.99	16.00
17.00 SUBPROVIDER - IRF	2,361	190	3,118	0.00	20.80	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00 NURSING FACILITY		0	0	0.00	0.00	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	732.04	27.00
28.00 Observation Bed Days		761	3,081			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	710	1,191			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: 15-0015

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
3/31/2017 12:53 pm

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	2,675	1,043	5,407	1.00
2.00 HMO and other (see instructions)			338	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,675	1,043	5,407	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	82	221	436	16.00
17.00 SUBPROVIDER - IRF	0.00	0	178	12	219	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY	0.00					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: 15-0015

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
3/31/2017 12:53 pm

	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	46,886,858	0	46,886,858	1,522,636.27	30.79
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		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
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)		3,786,726	0	3,786,726	134,349.95	28.19
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract Labor: Direct Patient Care		879,874	0	879,874	16,920.00	52.00
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		495,515	0	495,515	3,072.19	161.29
14.00	Home office and/or related organization salaries and wage-related costs		10,046,312	0	10,046,312	250,711.51	40.07
14.01	Home office salaries		0	0	0	0.00	0.00
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)		12,353,032	0	12,353,032		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		1,142,665	0	1,142,665		
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		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
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		0	0	0		
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	1,105,326	0	1,105,326	24,439.75	45.23
27.00	Administrative & General	5.00	4,494,789	0	4,494,789	138,540.09	32.44

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0015

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
3/31/2017 12:53 pm

		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.)		56,299	0	56,299	293.00	192.15	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,206,886	0	2,206,886	80,553.42	27.40	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,226,084	0	1,226,084	83,388.44	14.70	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,149,271	-827,985	321,286	18,327.77	17.53	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	827,985	827,985	47,222.19	17.53	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,044,932	0	2,044,932	58,849.31	34.75	38.00
39.00	Central Services and Supply	14.00	107,582	0	107,582	6,391.75	16.83	39.00
40.00	Pharmacy	15.00	1,876,952	0	1,876,952	48,437.47	38.75	40.00
41.00	Medical Records & Medical Records Library	16.00	6,877	0	6,877	361.71	19.01	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00



HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0015

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
3/31/2017 12:53 pm

	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)	46,943,157	0	46,943,157	1,522,929.27	30.82	1.00
2.00	Excluded area salaries (see instructions)	3,786,726	0	3,786,726	134,349.95	28.19	2.00
3.00	Subtotal salaries (line 1 minus line 2)	43,156,431	0	43,156,431	1,388,579.32	31.08	3.00
4.00	Subtotal other wages & related costs (see inst.)	11,421,701	0	11,421,701	270,703.70	42.19	4.00
5.00	Subtotal wage-related costs (see inst.)	12,353,032	0	12,353,032	0.00	28.62	5.00
6.00	Total (sum of lines 3 thru 5)	66,931,164	0	66,931,164	1,659,283.02	40.34	6.00
7.00	Total overhead cost (see instructions)	14,274,998	0	14,274,998	506,804.90	28.17	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part IV Date/Time Prepared: 3/31/2017 12:53 pm
				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		635,505	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)		2,443,333	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)		5,045,874	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		0	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		501,416	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		26,800	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)		476,402	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		889,358	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		3,362,433	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		11,847	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		102,729	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		13,495,697	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: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part V Date/Time Prepared: 3/31/2017 12:53 pm
Cost Center Description			Contract Labor	Benefit Cost
PART V - Contract Labor and Benefit Cost			1.00	2.00
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	0 1.00
2.00	Hospital		0	0 2.00
3.00	Subprovider - IPF		0	0 3.00
4.00	Subprovider - IRF		0	0 4.00
5.00	Subprovider - (Other)		0	0 5.00
6.00	Swing Beds - SNF		0	0 6.00
7.00	Swing Beds - NF		0	0 7.00
8.00	Hospital-Based SNF		0	0 8.00
9.00	Hospital-Based NF		0	0 9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other		0	0 18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet S-10	Date/Time Prepared: 3/31/2017 12: 53 pm
				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)			0.226558	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			18,043,501	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?			N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			127,884,430	6.00
7.00	Medicaid cost (line 1 times line 6)			28,973,241	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)			10,929,740	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			10,929,740	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)	4,320,708	26,351,666	30,672,374	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	978,891	5,970,181	6,949,072	21.00
22.00	Partial payment by patients approved for charity care	87,000	1,732,300	1,819,300	22.00
23.00	Cost of charity care (line 21 minus line 22)	891,891	4,237,881	5,129,772	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)			1,215,888	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			763,138	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			452,750	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			102,574	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			5,232,346	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			16,162,086	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0015

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

Worksheet A  
Date/Time Prepared:  
3/31/2017 12:53 pm

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 CAP REL COSTS-BLDG & FIXT		15,373,927	15,373,927	-7,552,463	7,821,464	1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP		0	0	8,192,127	8,192,127	2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1,105,326	13,705,213	14,810,539	-6,232	14,804,307	4.00	
5.00 00500 ADMIN STRATIVE & GENERAL	4,494,789	29,365,519	33,860,308	-16,496	33,843,812	5.00	
7.00 00700 OPERATION OF PLANT	2,206,886	3,810,198	6,017,084	-764	6,016,320	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	0	461,291	461,291	0	461,291	8.00	
9.00 00900 HOUSEKEEPING	1,226,084	340,361	1,566,445	-9,969	1,556,476	9.00	
10.00 01000 DIETARY	1,149,271	654,806	1,804,077	-1,302,542	501,535	10.00	
11.00 01100 CAFETERIA	0	0	0	1,299,736	1,299,736	11.00	
13.00 01300 NURSING ADMINISTRATION	2,044,932	896,138	2,941,070	-37	2,941,033	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	107,582	1,673,867	1,781,449	-326,737	1,454,712	14.00	
15.00 01500 PHARMACY	1,876,952	12,454,513	14,331,465	-54,688	14,276,777	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	6,877	1,847,679	1,854,556	0	1,854,556	16.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	9,768,979	1,551,755	11,320,734	-1,839,021	9,481,713	30.00	
31.00 03100 INTENSIVE CARE UNIT	2,101,552	180,299	2,281,851	-162,172	2,119,679	31.00	
40.00 04000 SUBPROVIDER - I PF	1,126,186	264,662	1,390,848	-6,179	1,384,669	40.00	
41.00 04100 SUBPROVIDER - I RF	1,289,550	300,838	1,590,388	-34,749	1,555,639	41.00	
43.00 04300 NURSERY	0	0	0	474,479	474,479	43.00	
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00	
45.00 04500 NURSING FACILITY	0	0	0	0	0	45.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	4,274,565	9,553,261	13,827,826	-8,522,528	5,305,298	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	850,802	850,802	52.00	
53.00 05300 ANESTHESIOLOGY	42,734	50,358	93,092	0	93,092	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,869,513	997,930	3,867,443	-295,806	3,571,637	54.00	
54.01 05401 FSED RADIOLOGY - DIAGNOSTIC	351,469	152,973	504,442	-37,330	467,112	54.01	
55.00 05500 RADIOLOGY-THERAPEUTIC	668,161	1,481,870	2,150,031	-10,536	2,139,495	55.00	
55.01 05501 WOODLAND CANCER CARE CENTER	654,895	396,361	1,051,256	-40,306	1,010,950	55.01	
57.00 05700 CT SCAN	0	0	0	0	0	57.00	
58.00 05800 MRI	0	0	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	760,769	2,558,290	3,319,059	-2,140,643	1,178,416	59.00	
60.00 06000 LABORATORY	0	5,687,792	5,687,792	-2,792	5,685,000	60.00	
60.01 06001 FSED LABORATORY	0	1,658,762	1,658,762	-2,907	1,655,855	60.01	
65.00 06500 RESPIRATORY THERAPY	852,380	217,266	1,069,646	-67,993	1,001,653	65.00	
66.00 06600 PHYSICAL THERAPY	551,346	2,515,348	3,066,694	-29,898	3,036,796	66.00	
69.00 06900 ELECTROCARDIOLOGY	780,461	216,724	997,185	-23,736	973,449	69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,807,083	7,807,083	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,255,169	4,255,169	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
76.00 03950 CV RESOURCE CENTER	18,991	0	18,991	0	18,991	76.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	0	0	0	0	0	90.00	
90.01 09001 OB CLINIC	0	0	0	0	0	90.01	
90.02 09002 PAIN MANAGEMENT	0	0	0	0	0	90.02	
90.03 09003 INFUSION OP SERVICES	761,415	657,354	1,418,769	-13,477	1,405,292	90.03	
90.04 09004 MATERNAL HEA	0	0	0	0	0	90.04	
91.00 09100 EMERGENCY	3,231,210	1,660,891	4,892,101	-276,433	4,615,668	91.00	
91.01 09101 FREE STANDING EMERGENCY DEPT	1,192,993	14,379	1,207,372	-49,847	1,157,525	91.01	
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)	45,515,868	110,700,625	156,216,493	53,115	156,269,608	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
194.00 07950 RETAIL PHARMACY	0	0	0	0	0	194.00	
194.01 07951 WORKING WELL	1,012,584	386,411	1,398,995	-52,917	1,346,078	194.01	
194.02 07952 APS DUNELAND SURG ASSOC	0	0	0	0	0	194.02	
194.03 07953 MED WATCH	0	0	0	0	0	194.03	
194.04 07954 OCCUPATIONAL MED CENTER	0	0	0	0	0	194.04	
194.05 07955 PHYSICIAN PRACTICE	0	0	0	0	0	194.05	
194.06 07956 DENTAL SERVICES	0	0	0	0	0	194.06	
194.07 07957 DUNELAND MED WATCH	0	0	0	0	0	194.07	
194.08 07958 WESTVILLE CLINIC	0	0	0	0	0	194.08	
194.09 07959 ORTHOPEDICS	0	0	0	0	0	194.09	
194.10 07960 WOMEN SERVICES	0	0	0	0	0	194.10	
194.11 07961 DUNELAND FITNESS CENTER	0	153	153	0	153	194.11	
194.12 07962 CARDIOLOGY ASSOC	0	0	0	0	0	194.12	
194.13 07963 DUNELAND FAMILY PRACTICE	0	0	0	0	0	194.13	
194.14 07964 ORTHOPEDICS	0	0	0	0	0	194.14	
194.15 07965 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.15	
194.16 07966 PHYSICIAN PRACTICE MD WISE	43,952	10,200,434	10,244,386	0	10,244,386	194.16	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0015		Period: From 01/01/2016 To 12/31/2016		Worksheet A Date/Time Prepared: 3/31/2017 12:53 pm	
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
194.17	07967 ENT	0	0	0	0	0	194.17
194.18	07968 SLEEP CLINIC	0	0	0	0	0	194.18
194.19	07969 HEALTH PARTNERS	294,005	6,440	300,445	-198	300,247	194.19
194.20	07970 CENTER OF HOPE	20,449	2,000	22,449	0	22,449	194.20
200.00	TOTAL (SUM OF LINES 118-199)	46,886,858	121,296,063	168,182,921	0	168,182,921	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0015

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

Worksheet A  
Date/Time Prepared:  
3/31/2017 12:53 pm

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	-1,849,788	5,971,676	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	8,192,127	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,243,495	16,047,802	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-7,491,515	26,352,297	5.00
7.00	00700	OPERATION OF PLANT	-57,738	5,958,582	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	461,291	8.00
9.00	00900	HOUSEKEEPING	0	1,556,476	9.00
10.00	01000	DIETARY	-69,632	431,903	10.00
11.00	01100	CAFETERIA	-640,041	659,695	11.00
13.00	01300	NURSING ADMINISTRATION	-35,676	2,905,357	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-83,747	1,370,965	14.00
15.00	01500	PHARMACY	-28,553	14,248,224	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-471,009	1,383,547	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-91,627	9,390,086	30.00
31.00	03100	INTENSIVE CARE UNIT	-9,000	2,110,679	31.00
40.00	04000	SUBPROVIDER - I PF	-3,544	1,381,125	40.00
41.00	04100	SUBPROVIDER - I RF	0	1,555,639	41.00
43.00	04300	NURSERY	0	474,479	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-898,777	4,406,521	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	850,802	52.00
53.00	05300	ANESTHESIOLOGY	-2,284	90,808	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-70,494	3,501,143	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	0	467,112	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	-398,042	1,741,453	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	-27,620	983,330	55.01
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	-10,240	1,168,176	59.00
60.00	06000	LABORATORY	-27,526	5,657,474	60.00
60.01	06001	FSED LABORATORY	0	1,655,855	60.01
65.00	06500	RESPIRATORY THERAPY	-8,281	993,372	65.00
66.00	06600	PHYSICAL THERAPY	-21,861	3,014,935	66.00
69.00	06900	ELECTROCARDIOLOGY	0	973,449	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-138,128	7,668,955	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,255,169	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-180,616	-180,616	73.00
76.00	03950	CV RESOURCE CENTER	0	18,991	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OB CLINIC	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	90.02
90.03	09003	INFUSION OP SERVICES	-309	1,404,983	90.03
90.04	09004	MATERNAL HEA	0	0	90.04
91.00	09100	EMERGENCY	0	4,615,668	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	531,685	1,689,210	91.01
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)	-10,840,868	145,428,740	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	RETAIL PHARMACY	0	0	194.00
194.01	07951	WORKING WELL	0	1,346,078	194.01
194.02	07952	APS DUNELAND SURG ASSOC	0	0	194.02
194.03	07953	MED WATCH	0	0	194.03
194.04	07954	OCCUPATIONAL MED CENTER	0	0	194.04
194.05	07955	PHYSICIAN PRACTICE	0	0	194.05
194.06	07956	DENTAL SERVICES	0	0	194.06
194.07	07957	DUNELAND MED WATCH	0	0	194.07
194.08	07958	WESTVILLE CLINIC	0	0	194.08
194.09	07959	ORTHOPEDICS	0	0	194.09
194.10	07960	WOMEN SERVICES	0	0	194.10
194.11	07961	DUNELAND FITNESS CENTER	0	153	194.11
194.12	07962	CARDIOLOGY ASSOC	0	0	194.12
194.13	07963	DUNELAND FAMILY PRACTICE	0	0	194.13
194.14	07964	ORTHOPEDICS	0	0	194.14
194.15	07965	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.15
194.16	07966	PHYSICIAN PRACTICE MD WISE	0	10,244,386	194.16
194.17	07967	ENT	0	0	194.17
194.18	07968	SLEEP CLINIC	0	0	194.18

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet A Date/Time Prepared: 3/31/2017 12:53 pm
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Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
194.19	07969 HEALTH PARTNERS	0	300,247	194.19
194.20	07970 CENTER OF HOPE	0	22,449	194.20
200.00	TOTAL (SUM OF LINES 118-199)	-10,840,868	157,342,053	200.00



		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
<b>A - CAPITAL</b>						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,192,127	1.00	
	O		0	8,192,127		
<b>B - CAFETERIA</b>						
1.00	CAFETERIA	11.00	827,985	471,751	1.00	
	O		827,985	471,751		
<b>C - WORKER'S COMPENSATION</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1	1.00	
	O		0	1		
<b>D - MEDICAL SUPPLIES</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	11,308,608	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	
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	
	O		0	11,308,608		
<b>E - MEDICAL SUPPLIES - PACEMAKERS</b>						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	753,644	1.00	
	O		0	753,644		
<b>F - NURSERY AND LABOR/DELIVERY</b>						
1.00	NURSERY	43.00	405,903	68,576	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	727,836	122,966	2.00	
	O		1,133,739	191,542		
<b>G - DEPRECIATION</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	617,640	1.00	
	O		0	617,640		
<b>H - INTEREST</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	22,024	1.00	
	O		0	22,024		
<b>I - IMPLANTABLE DEVICES</b>						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,501,525	1.00	
	O		0	3,501,525		
500.00	Grand Total: Increases		1,961,724	25,058,862	500.00	

RECLASSIFICATIONS

Provider CCN: 15-0015

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

Worksheet A-6  
Date/Time Prepared:  
3/31/2017 12:53 pm

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
<b>A - CAPITAL</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,192,127	9	1.00
	O		0	8,192,127		
<b>B - CAFETERIA</b>						
1.00	DIETARY	10.00	827,985	471,751	0	1.00
	O		827,985	471,751		
<b>C - WORKER'S COMPENSATION</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1	0	1.00
	O		0	1		
<b>D - MEDICAL SUPPLIES</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,233	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	16,495	0	2.00
3.00	OPERATION OF PLANT	7.00	0	764	0	3.00
4.00	HOUSEKEEPING	9.00	0	9,969	0	4.00
5.00	DIETARY	10.00	0	2,806	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	37	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	326,737	0	7.00
8.00	PHARMACY	15.00	0	54,688	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	513,740	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	162,172	0	10.00
11.00	SUBPROVIDER - IPF	40.00	0	6,179	0	11.00
12.00	SUBPROVIDER - IRF	41.00	0	34,749	0	12.00
13.00	OPERATING ROOM	50.00	0	7,882,864	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	295,806	0	14.00
15.00	FSED RADIOLOGY - DIAGNOSTIC	54.01	0	37,330	0	15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	10,536	0	16.00
17.00	WOODLAND CANCER CARE CENTER	55.01	0	40,306	0	17.00
18.00	CARDIAC CATHETERIZATION	59.00	0	1,386,999	0	18.00
19.00	LABORATORY	60.00	0	2,792	0	19.00
20.00	FSED LABORATORY	60.01	0	2,907	0	20.00
21.00	RESPIRATORY THERAPY	65.00	0	67,993	0	21.00
22.00	PHYSICAL THERAPY	66.00	0	29,898	0	22.00
23.00	ELECTROCARDIOLOGY	69.00	0	23,736	0	23.00
25.00	INFUSION OP SERVICES	90.03	0	13,477	0	25.00
26.00	EMERGENCY	91.00	0	276,433	0	26.00
27.00	FREE STANDING EMERGENCY DEPT	91.01	0	49,847	0	27.00
28.00	WORKING WELL	194.01	0	52,917	0	28.00
29.00	HEALTH PARTNERS	194.19	0	198	0	29.00
	O		0	11,308,608		
<b>E - MEDICAL SUPPLIES - PACEMAKERS</b>						
1.00	CARDIAC CATHETERIZATION	59.00	0	753,644	0	1.00
	O		0	753,644		
<b>F - NURSERY AND LABOR/DELIVERY</b>						
1.00	ADULTS & PEDIATRICS	30.00	1,133,739	191,542	0	1.00
2.00		0.00	0	0	0	2.00
	O		1,133,739	191,542		
<b>G - DEPRECIATION</b>						
1.00	OPERATING ROOM	50.00	0	617,640	9	1.00
	O		0	617,640		
<b>H - INTEREST</b>						
1.00	OPERATING ROOM	50.00	0	22,024	11	1.00
	O		0	22,024		
<b>I - IMPLANTABLE DEVICES</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,501,525	0	1.00
	O		0	3,501,525		
500.00	Grand Total: Decreases		1,961,724	25,058,862		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0015

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
3/31/2017 12:53 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	7,180,112	0	0	0	0	1.00
2.00	Land Improvements	4,035,217	9,246	0	9,246	0	2.00
3.00	Buildings and Fixtures	92,807,720	1,107	0	1,107	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	4,316,923	0	0	0	0	5.00
6.00	Movable Equipment	106,590,568	10,421,278	0	10,421,278	4,893,562	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	214,930,540	10,431,631	0	10,431,631	4,893,562	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	214,930,540	10,431,631	0	10,431,631	4,893,562	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	7,180,112	0				1.00
2.00	Land Improvements	4,044,463	1,533,892				2.00
3.00	Buildings and Fixtures	92,808,827	12,630,557				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	4,316,923	0				5.00
6.00	Movable Equipment	112,118,284	19,521,202				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	220,468,609	33,685,651				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	220,468,609	33,685,651				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0015

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
3/31/2017 12:53 pm

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	15,373,927	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)	15,373,927	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	15,373,927				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	15,373,927				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0015

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
3/31/2017 12:53 pm

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	104,033,402	0	104,033,402	0.471874	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	116,435,208	0	116,435,208	0.528126	0	2.00
3.00	Total (sum of lines 1-2)	220,468,610	0	220,468,610	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col.s. 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	9,502,599	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	8,192,127	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	17,694,726	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 col.s. 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	-3,234,532	0	0	-296,391	5,971,676	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	8,192,127	2.00
3.00	Total (sum of lines 1-2)	-3,234,532	0	0	-296,391	14,163,803	3.00

Line #	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			3.00
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)	B	-29,674		CAP REL COSTS-BLDG & FIXT	1.00	11	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)	B	-5,243		ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0			0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0			0.00	0	7.00
8.00	Television and radio service (chapter 21)		0			0.00	0	8.00
9.00	Parking lot (chapter 21)		0			0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,324,935				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	-1,556,768				0	12.00
13.00	Laundry and linen service		0			0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-623,253		CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0			0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0			0.00	0	16.00
17.00	Sale of drugs to other than patients		0			0.00	0	17.00
18.00	Sale of medical records and abstracts		0			0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0			0.00	0	19.00
20.00	Vending machines	B	-16,788		CAFETERIA	11.00	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			RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3			PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)				*** 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			*** Cost Center Deleted ***	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			*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00	UNCLAI MED PROPERTY	B		1	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	OTHER	A		1	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0015

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

Worksheet A-8

Date/Time Prepared:  
3/31/2017 12:53 pm

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	3.00	
34.00	A		1	ADMINISTRATIVE & GENERAL	5.00	0 34.00
35.00	B		1	ADMINISTRATIVE & GENERAL	5.00	0 35.00
36.00	B	-277		ADULTS & PEDIATRICS	30.00	0 36.00
37.00	A	-7,731		ADMINISTRATIVE & GENERAL	5.00	0 37.00
38.00	A	31,132		ADMINISTRATIVE & GENERAL	5.00	0 38.00
39.00	B		1	ADMINISTRATIVE & GENERAL	5.00	0 39.00
40.00	B	-11,077		ADMINISTRATIVE & GENERAL	5.00	0 40.00
41.00	A	-2,179		ADMINISTRATIVE & GENERAL	5.00	0 41.00
42.00	B		1	ADMINISTRATIVE & GENERAL	5.00	0 42.00
43.00	B	-57,653		OPERATION OF PLANT	7.00	0 43.00
44.00	A	-296,391		CAP REL COSTS-BLDG & FIXT	1.00	14 44.00
45.00	A	-9,655		ADMINISTRATIVE & GENERAL	5.00	0 45.00
46.00	B		1	FREE STANDING EMERGENCY DEPT	91.01	0 46.00
47.00	B	-68,712		DIETARY	10.00	0 47.00
48.00	B	-180,616		DRUGS CHARGED TO PATIENTS	73.00	0 48.00
49.00	A	-6,093,931		ADMINISTRATIVE & GENERAL	5.00	0 49.00
49.01	A	1,245,229		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 49.01
49.02	B	-9,292		ADMINISTRATIVE & GENERAL	5.00	0 49.02
49.03	B		-85	OPERATION OF PLANT	7.00	10 49.03
49.04	B	-58,624		OPERATING ROOM	50.00	0 49.04
49.05	B	-191,238		OPERATING ROOM	50.00	0 49.05
49.06	B	-70,403		RADIOLOGY-DIAGNOSTIC	54.00	0 49.06
49.07	B	-20,322		WOODLAND CANCER CARE CENTER	55.01	0 49.07
49.08	B	-11,375		LABORATORY	60.00	0 49.08
49.09	B	-5,781		RESPIRATORY THERAPY	65.00	0 49.09
49.10	B	-740		PHYSICAL THERAPY	66.00	0 49.10
49.11	B	-69,353		MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0 49.11
49.12	B	-68,775		MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0 49.12
49.13	B		1	PHARMACY	15.00	0 49.13
49.14	B		1	OPERATING ROOM	50.00	0 49.14
49.15	B	-909		ADMINISTRATIVE & GENERAL	5.00	0 49.15
49.16		0			0.00	0 49.16
49.17	B	-15,482		ADMINISTRATIVE & GENERAL	5.00	0 49.17
49.18	B	-307,793		OPERATING ROOM	50.00	0 49.18
49.19	B	-1,263		WOODLAND CANCER CARE CENTER	55.01	0 49.19
49.20	B	-920		DIETARY	10.00	0 49.20
50.00		-10,840,868		TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		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: 15-0015

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

Worksheet A-8-1

Date/Time Prepared:  
3/31/2017 12:53 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST	1,050,732	4,277,614 1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	ALLOWABLE NEW CAP COSTS	1,703,160	1 2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	13,166,050	12,620,033 3.00
4.00	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SERVICE	1	83,748 4.00
4.01	15.00	PHARMACY	COEP/PHARM	213,954	238,260 4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	HIM	1,348,183	1,819,192 4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			17,482,080	19,038,848 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	Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

6.00	B	100.00	FRANCISCAN ALLI	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	G	0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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



STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-0015

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

Worksheet A-8-1

Date/Time Prepared:  
3/31/2017 12:53 pm

	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	-3,226,882	11		1.00
2.00	1,703,159	9		2.00
3.00	546,017	0		3.00
4.00	-83,747	0		4.00
4.01	-24,306	0		4.01
4.02	-471,009	0		4.02
5.00	-1,556,768			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	HEALTHCARE SERV		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: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet A-8-2 Date/Time Prepared: 3/31/2017 12:53 pm
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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	4.00	EMPLOYEE BENEFITS DEPARTMENT	1,734	1,734	0	179,000	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	1,997,773	1,886,460	111,313	197,500	891	2.00
3.00	13.00	NURSING ADMINISTRATION	37,005	35,255	1,750	197,500	14	3.00
4.00	15.00	PHARMACY	9,375	0	9,375	197,500	54	4.00
5.00	30.00	ADULTS & PEDIATRICS	118,316	82,821	35,495	197,500	284	5.00
6.00	31.00	INTENSIVE CARE UNIT	9,000	9,000	0	211,500	0	6.00
7.00	40.00	SUBPROVIDER - IPF	14,938	0	14,938	197,500	120	7.00
8.00	50.00	OPERATING ROOM	444,895	247,749	197,146	246,400	876	8.00
9.00	53.00	ANESTHESIOLOGY	9,996	0	9,996	239,400	67	9.00
10.00	54.00	RADIOLOGY-DIAGNOSTIC	91	91	0	211,500	0	10.00
11.00	55.00	RADIOLOGY-THERAPEUTIC	398,042	398,042	0	211,500	0	11.00
12.00	55.01	WOODLAND CANCER CARE CENTER	16,312	6,035	10,277	271,900	82	12.00
13.00	59.00	CARDIAC CATHETERIZATION	30,750	3,690	27,060	197,500	216	13.00
14.00	60.00	LABORATORY	54,417	0	54,417	197,500	403	14.00
15.00	65.00	RESPIRATORY THERAPY	2,500	2,500	0	197,500	0	15.00
16.00	66.00	PHYSICAL THERAPY	38,687	0	38,687	197,500	185	16.00
17.00	90.03	INFUSION SERVICES	309	309	0	211,500	0	17.00
18.00	91.01	FREE STANDING EMERGENCY DEPT	-531,684	-531,684	0	197,500	0	18.00
200.00			2,652,456	2,142,002	510,454		3,192	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	84,602	4,230	0	0	0	2.00
3.00	13.00	NURSING ADMINISTRATION	1,329	66	0	0	0	3.00
4.00	15.00	PHARMACY	5,127	256	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	26,966	1,348	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	6.00
7.00	40.00	SUBPROVIDER - IPF	11,394	570	0	0	0	7.00
8.00	50.00	OPERATING ROOM	103,772	5,189	0	0	0	8.00
9.00	53.00	ANESTHESIOLOGY	7,712	386	0	0	0	9.00
10.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	10.00
11.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	11.00
12.00	55.01	WOODLAND CANCER CARE CENTER	10,719	536	0	0	0	12.00
13.00	59.00	CARDIAC CATHETERIZATION	20,510	1,026	0	0	0	13.00
14.00	60.00	LABORATORY	38,266	1,913	0	0	0	14.00
15.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	15.00
16.00	66.00	PHYSICAL THERAPY	17,566	878	0	0	0	16.00
17.00	90.03	INFUSION SERVICES	0	0	0	0	0	17.00
18.00	91.01	FREE STANDING EMERGENCY DEPT	0	0	0	0	0	18.00
200.00			327,963	16,398	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,734	1.00	
2.00	5.00	ADMINISTRATIVE & GENERAL	0	84,602	26,711	1,913,171	2.00
3.00	13.00	NURSING ADMINISTRATION	0	1,329	421	35,676	3.00
4.00	15.00	PHARMACY	0	5,127	4,248	4,248	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	26,966	8,529	91,350	5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	9,000	6.00
7.00	40.00	SUBPROVIDER - IPF	0	11,394	3,544	3,544	7.00
8.00	50.00	OPERATING ROOM	0	103,772	93,374	341,123	8.00
9.00	53.00	ANESTHESIOLOGY	0	7,712	2,284	2,284	9.00
10.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	91	10.00
11.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	398,042	11.00
12.00	55.01	WOODLAND CANCER CARE CENTER	0	10,719	0	6,035	12.00
13.00	59.00	CARDIAC CATHETERIZATION	0	20,510	6,550	10,240	13.00
14.00	60.00	LABORATORY	0	38,266	16,151	16,151	14.00
15.00	65.00	RESPIRATORY THERAPY	0	0	0	2,500	15.00
16.00	66.00	PHYSICAL THERAPY	0	17,566	21,121	21,121	16.00
17.00	90.03	INFUSION SERVICES	0	0	0	309	17.00
18.00	91.01	FREE STANDING EMERGENCY DEPT	0	0	0	-531,684	18.00
200.00			0	327,963	182,933	2,324,935	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0015

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

Worksheet B  
Part I  
Date/Time Prepared:  
3/31/2017 12:53 pm

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	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	5,971,676	5,971,676			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	8,192,127		8,192,127		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	16,047,802	57,551	13,234	16,118,587	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	26,352,297	861,561	883,744	1,582,507	5.00
7.00 00700	OPERATION OF PLANT	5,958,582	751,476	996,861	776,992	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	461,291	66,346	159	0	8.00
9.00 00900	HOUSEKEEPING	1,556,476	108,925	22,448	431,675	9.00
10.00 01000	DIETARY	431,903	47,533	22,287	113,117	10.00
11.00 01100	CAFETERIA	659,695	112,736	0	291,514	11.00
13.00 01300	NURSING ADMINISTRATION	2,905,357	27,100	245,566	719,971	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,370,965	104,814	102,569	37,877	14.00
15.00 01500	PHARMACY	14,248,224	50,137	3,632	660,830	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,383,547	46,422	9,886	2,421	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	9,390,086	1,043,356	106,042	3,040,266	30.00
31.00 03100	INTENSIVE CARE UNIT	2,110,679	93,621	164,286	739,906	31.00
40.00 04000	SUBPROVIDER - I/PF	1,381,125	99,384	4,552	396,503	40.00
41.00 04100	SUBPROVIDER - I/RF	1,555,639	179,875	34,130	454,020	41.00
43.00 04300	NURSERY	474,479	14,273	313	142,909	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	4,406,521	300,232	1,532,205	1,504,972	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	850,802	114,498	0	256,254	52.00
53.00 05300	ANESTHESIOLOGY	90,808	8,668	9,822	15,046	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,501,143	287,499	901,787	1,010,287	54.00
54.01 05401	FSED RADIOLOGY - DIAGNOSTIC	467,112	45,485	580,014	123,744	54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	1,741,453	142,186	104,675	235,243	55.00
55.01 05501	WOODLAND CANCER CARE CENTER	983,330	169,651	1,192,234	230,573	55.01
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,168,176	68,759	445,791	267,849	59.00
60.00 06000	LABORATORY	5,657,474	142,551	7,643	0	60.00
60.01 06001	FSED LABORATORY	1,655,855	20,639	147	0	60.01
65.00 06500	RESPIRATORY THERAPY	993,372	31,800	27,612	300,103	65.00
66.00 06600	PHYSICAL THERAPY	3,014,935	21,909	10,815	194,116	66.00
69.00 06900	ELECTROCARDIOLOGY	973,449	87,858	100,025	274,782	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,668,955	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	4,255,169	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	-180,616	0	0	0	73.00
76.00 03950	CV RESOURCE CENTER	18,991	0	0	6,686	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 09001	OB CLINIC	0	0	0	0	90.01
90.02 09002	PAIN MANAGEMENT	0	0	0	0	90.02
90.03 09003	INFUSION OP SERVICES	1,404,983	22,115	987	268,076	90.03
90.04 09004	MATERNAL HEA	0	0	0	0	90.04
91.00 09100	EMERGENCY	4,615,668	318,981	124,564	1,137,631	91.00
91.01 09101	FREE STANDING EMERGENCY DEPT	1,689,210	339,446	386,515	420,024	91.01
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)	145,428,740	5,787,387	8,034,545	15,635,894	144,604,176
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,638	0	0	190.00
194.00 07950	RETAIL PHARMACY	0	0	0	0	194.00
194.01 07951	WORKING WELL	1,346,078	0	110,520	356,507	194.01
194.02 07952	APS DUNELAND SURG ASSOC	0	0	0	0	194.02
194.03 07953	MED WATCH	0	96,526	0	0	194.03
194.04 07954	OCCUPATIONAL MED CENTER	0	0	0	0	194.04
194.05 07955	PHYSICIAN PRACTICE	0	0	0	0	194.05
194.06 07956	DENTAL SERVICES	0	0	0	0	194.06
194.07 07957	DUNELAND MED WATCH	0	0	0	0	194.07
194.08 07958	WESTVILLE CLINIC	0	0	0	0	194.08
194.09 07959	ORTHOPEDICS	0	0	0	0	194.09
194.10 07960	WOMEN SERVICES	0	72,125	0	0	194.10
194.11 07961	DUNELAND FITNESS CENTER	153	0	30,460	0	194.11
194.12 07962	CARDIOLOGY ASSOC	0	0	0	0	194.12
194.13 07963	DUNELAND FAMILY PRACTICE	0	0	0	0	194.13

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0015

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

Worksheet B  
Part I  
Date/Time Prepared:  
3/31/2017 12:53 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
194.14 07964 ORTHOPEDICS	0	0	0	0	0	194.14
194.15 07965 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.15
194.16 07966 PHYSICIAN PRACTICE MD WISE	10,244,386	0	10,738	15,474	10,270,598	194.16
194.17 07967 ENT	0	0	0	0	0	194.17
194.18 07968 SLEEP CLINIC	0	0	0	0	0	194.18
194.19 07969 HEALTH PARTNERS	300,247	0	5,402	103,512	409,161	194.19
194.20 07970 CENTER OF HOPE	22,449	0	462	7,200	30,111	194.20
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	157,342,053	5,971,676	8,192,127	16,118,587	157,342,053	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0015

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

Worksheet B  
Part I  
Date/Time Prepared:  
3/31/2017 12:53 pm

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	29,680,109				5.00
7.00	00700	OPERATION OF PLANT	1,969,633	10,453,544			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	122,534	161,250	811,580		8.00
9.00	00900	HOUSEKEEPING	492,071	264,737	0	2,876,332	9.00
10.00	01000	DIETARY	142,742	115,526	325	33,138	906,571
11.00	01100	CAFETERIA	247,007	273,998	0	78,594	0
13.00	01300	NURSING ADMINISTRATION	904,962	65,866	0	18,893	0
14.00	01400	CENTRAL SERVICES & SUPPLY	375,224	254,743	0	73,071	0
15.00	01500	PHARMACY	3,473,835	121,854	0	34,953	0
16.00	01600	MEDICAL RECORDS & LIBRARY	334,840	112,825	0	32,363	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	3,152,688	2,535,816	381,440	727,383	580,195
31.00	03100	INTENSIVE CARE UNIT	721,671	227,540	40,579	65,268	94,180
40.00	04000	SUBPROVIDER - I/PF	436,826	241,547	89,274	69,286	99,497
41.00	04100	SUBPROVIDER - I/RF	516,248	437,177	32,464	125,401	98,047
43.00	04300	NURSERY	146,720	34,689	244	9,950	34,652
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00	04500	NURSING FACILITY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,797,839	729,696	43,014	209,308	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	283,597	278,281	0	79,823	0
53.00	05300	ANESTHESIOLOGY	28,868	21,068	0	6,043	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,323,484	698,750	32,625	200,431	0
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	282,390	110,548	0	31,710	0
55.00	05500	RADIOLOGY-THERAPEUTIC	516,223	345,574	406	99,125	0
55.01	05501	WOODLAND CANCER CARE CENTER	597,998	412,328	8,115	118,273	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	452,847	167,115	244	47,936	0
60.00	06000	LABORATORY	1,348,314	346,462	0	99,380	0
60.01	06001	FSED LABORATORY	389,251	50,162	0	14,388	0
65.00	06500	RESPIRATORY THERAPY	314,088	77,287	0	22,169	0
66.00	06600	PHYSICAL THERAPY	752,614	53,248	24,347	15,274	0
69.00	06900	ELECTROCARDIOLOGY	333,410	213,534	4,058	61,251	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,780,432	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	987,884	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03950	CV RESOURCE CENTER	5,961	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	OB CLINIC	0	0	0	0	0
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0
90.03	09003	INFUSION OP SERVICES	393,782	53,750	244	15,418	0
90.04	09004	MATERNAL HEA	0	0	0	0	0
91.00	09100	EMERGENCY	1,438,665	775,266	81,158	222,379	0
91.01	09101	FREE STANDING EMERGENCY DEPT	658,222	825,003	32,464	236,646	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,722,870	10,005,640	771,001	2,747,854	906,571
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,631	38,007	0	10,902	0
194.00	07950	RETAIL PHARMACY	0	0	0	0	0
194.01	07951	WORKING WELL	420,932	0	40,579	0	0
194.02	07952	APS DUNELAND SURG ASSOC	0	0	0	0	0
194.03	07953	MED WATCH	22,410	234,602	0	67,294	0
194.04	07954	OCCUPATIONAL MED CENTER	0	0	0	0	0
194.05	07955	PHYSICIAN PRACTICE	0	0	0	0	0
194.06	07956	DENTAL SERVICES	0	0	0	0	0
194.07	07957	DUNELAND MED WATCH	0	0	0	0	0
194.08	07958	WESTVILLE CLINIC	0	0	0	0	0
194.09	07959	ORTHOPEDICS	0	0	0	0	0
194.10	07960	WOMEN SERVICES	16,745	175,295	0	50,282	0
194.11	07961	DUNELAND FITNESS CENTER	7,107	0	0	0	0
194.12	07962	CARDIOLOGY ASSOC	0	0	0	0	0
194.13	07963	DUNELAND FAMILY PRACTICE	0	0	0	0	0
194.14	07964	ORTHOPEDICS	0	0	0	0	0
194.15	07965	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.16	07966	PHYSICIAN PRACTICE MD WISE	2,384,432	0	0	0	0
194.17	07967	ENT	0	0	0	0	0
194.18	07968	SLEEP CLINIC	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0015

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

Worksheet B  
Part I  
Date/Time Prepared:  
3/31/2017 12:53 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
194.19	07969 HEALTH PARTNERS	94,991	0	0	0	0	194.19
194.20	07970 CENTER OF HOPE	6,991	0	0	0	0	194.20
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)	29,680,109	10,453,544	811,580	2,876,332	906,571	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0015		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part I Date/Time Prepared: 3/31/2017 12:53 pm	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
<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	1,663,544					11.00
13.00	01300	NURSING ADMINISTRATION	88,180	4,975,895				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,569	0	2,328,832			14.00
15.00	01500	PHARMACY	72,595	0	0	18,666,060		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	623	0	0	0	1,922,927	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	377,595	1,556,080	0	0	115,646	30.00
31.00	03100	INTENSIVE CARE UNIT	83,941	558,687	0	0	20,076	31.00
40.00	04000	SUBPROVIDER - IPF	56,075	191,364	0	0	13,114	40.00
41.00	04100	SUBPROVIDER - IRF	64,834	208,938	0	0	23,669	41.00
43.00	04300	NURSERY	15,117	105,228	0	0	3,689	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	237,640	814,273	0	0	351,202	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,118	188,760	0	0	6,616	52.00
53.00	05300	ANESTHESIOLOGY	3,148	0	0	0	14,722	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	124,742	26,253	0	0	259,045	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	29,144	0	0	0	52,654	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	23,190	18,659	0	0	35,725	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	29,643	76,372	0	0	8,841	55.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	26,900	98,936	0	0	59,009	59.00
60.00	06000	LABORATORY	0	0	0	0	164,049	60.00
60.01	06001	FSED LABORATORY	0	0	0	0	20,722	60.01
65.00	06500	RESPIRATORY THERAPY	44,916	0	0	0	40,925	65.00
66.00	06600	PHYSICAL THERAPY	30,173	8,462	0	0	56,708	66.00
69.00	06900	ELECTROCARDIOLOGY	35,939	75,721	0	0	46,607	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,607,749	0	61,601	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	721,083	0	41,071	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	18,666,060	342,497	73.00
76.00	03950	CV RESOURCE CENTER	499	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OB CLINIC	0	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
90.03	09003	INFUSION OP SERVICES	10,255	60,750	0	0	4,488	90.03
90.04	09004	MATERNAL HEA	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	145,470	693,640	0	0	151,172	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	45,820	292,253	0	0	29,079	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,583,126	4,974,376	2,328,832	18,666,060	1,922,927	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	RETAIL PHARMACY	0	0	0	0	0	194.00
194.01	07951	WORKING WELL	76,709	217	0	0	0	194.01
194.02	07952	APS DUNELAND SURG ASSOC	0	0	0	0	0	194.02
194.03	07953	MED WATCH	0	0	0	0	0	194.03
194.04	07954	OCCUPATIONAL MED CENTER	0	0	0	0	0	194.04
194.05	07955	PHYSICIAN PRACTICE	0	0	0	0	0	194.05
194.06	07956	DENTAL SERVICES	0	0	0	0	0	194.06
194.07	07957	DUNELAND MED WATCH	0	0	0	0	0	194.07
194.08	07958	WESTVILLE CLINIC	0	0	0	0	0	194.08
194.09	07959	ORTHOPEDICS	0	0	0	0	0	194.09
194.10	07960	WOMEN SERVICES	0	0	0	0	0	194.10
194.11	07961	DUNELAND FITNESS CENTER	0	0	0	0	0	194.11
194.12	07962	CARDIOLOGY ASSOC	0	0	0	0	0	194.12
194.13	07963	DUNELAND FAMILY PRACTICE	0	0	0	0	0	194.13
194.14	07964	ORTHOPEDICS	0	0	0	0	0	194.14
194.15	07965	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.15
194.16	07966	PHYSICIAN PRACTICE MD WISE	2,525	0	0	0	0	194.16
194.17	07967	ENT	0	0	0	0	0	194.17

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0015

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

Worksheet B  
Part I  
Date/Time Prepared:  
3/31/2017 12:53 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
		11.00	13.00	14.00	15.00	16.00		
194.18	07968	SLEEP CLINIC	0	0	0	0	0	194.18
194.19	07969	HEALTH PARTNERS	0	0	0	0	0	194.19
194.20	07970	CENTER OF HOPE	1,184	1,302	0	0	0	194.20
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,663,544	4,975,895	2,328,832	18,666,060	1,922,927	202.00



COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0015

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

Worksheet B  
Part I  
Date/Time Prepared:  
3/31/2017 12:53 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	23,006,593	0	23,006,593	30.00
31.00	03100	INTENSIVE CARE UNIT	4,920,434	0	4,920,434	31.00
40.00	04000	SUBPROVIDER - IPF	3,078,547	0	3,078,547	40.00
41.00	04100	SUBPROVIDER - IRF	3,730,442	0	3,730,442	41.00
43.00	04300	NURSERY	982,263	0	982,263	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	11,926,902	0	11,926,902	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,085,749	0	2,085,749	52.00
53.00	05300	ANESTHESIOLOGY	198,193	0	198,193	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,366,046	0	8,366,046	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	1,722,801	0	1,722,801	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	3,262,459	0	3,262,459	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	3,827,358	0	3,827,358	55.01
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,803,562	0	2,803,562	59.00
60.00	06000	LABORATORY	7,765,873	0	7,765,873	60.00
60.01	06001	FSED LABORATORY	2,151,164	0	2,151,164	60.01
65.00	06500	RESPIRATORY THERAPY	1,852,272	0	1,852,272	65.00
66.00	06600	PHYSICAL THERAPY	4,182,601	0	4,182,601	66.00
69.00	06900	ELECTROCARDIOLOGY	2,206,634	0	2,206,634	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,118,737	0	11,118,737	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,005,207	0	6,005,207	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,827,941	0	18,827,941	73.00
76.00	03950	CV RESOURCE CENTER	32,137	0	32,137	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	0	0	90.00
90.01	09001	OB CLINIC	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	90.02
90.03	09003	INFUSION OP SERVICES	2,234,848	0	2,234,848	90.03
90.04	09004	MATERNAL HEA	0	0	0	90.04
91.00	09100	EMERGENCY	9,704,594	0	9,704,594	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	4,954,682	0	4,954,682	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		SUBTOTALS (SUM OF LINES 1-117)	140,948,039	0	140,948,039	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	68,178	0	68,178	190.00
194.00	07950	RETAIL PHARMACY	0	0	0	194.00
194.01	07951	WORKING WELL	2,351,542	0	2,351,542	194.01
194.02	07952	APS DUNELAND SURG ASSOC	0	0	0	194.02
194.03	07953	MED WATCH	420,832	0	420,832	194.03
194.04	07954	OCCUPATIONAL MED CENTER	0	0	0	194.04
194.05	07955	PHYSICIAN PRACTICE	0	0	0	194.05
194.06	07956	DENTAL SERVICES	0	0	0	194.06
194.07	07957	DUNELAND MED WATCH	0	0	0	194.07
194.08	07958	WESTVILLE CLINIC	0	0	0	194.08
194.09	07959	ORTHOPEDICS	0	0	0	194.09
194.10	07960	WOMEN SERVICES	314,447	0	314,447	194.10
194.11	07961	DUNELAND FITNESS CENTER	37,720	0	37,720	194.11
194.12	07962	CARDIOLOGY ASSOC	0	0	0	194.12
194.13	07963	DUNELAND FAMILY PRACTICE	0	0	0	194.13
194.14	07964	ORTHOPEDICS	0	0	0	194.14
194.15	07965	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.15

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0015

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

Worksheet B  
Part I  
Date/Time Prepared:  
3/31/2017 12:53 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
194.16	07966 PHYSICIAN PRACTICE MD WISE	12,657,555	0	12,657,555	194.16
194.17	07967 ENT	0	0	0	194.17
194.18	07968 SLEEP CLINIC	0	0	0	194.18
194.19	07969 HEALTH PARTNERS	504,152	0	504,152	194.19
194.20	07970 CENTER OF HOPE	39,588	0	39,588	194.20
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	157,342,053	0	157,342,053	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 3/31/2017 12: 53 pm
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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	57,551	13,234	70,785	70,785 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	861,561	883,744	1,745,305	6,949 5.00
7.00 00700	OPERATION OF PLANT	0	751,476	996,861	1,748,337	3,412 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	66,346	159	66,505	0 8.00
9.00 00900	HOUSEKEEPING	0	108,925	22,448	131,373	1,896 9.00
10.00 01000	DIETARY	0	47,533	22,287	69,820	497 10.00
11.00 01100	CAFETERIA	0	112,736	0	112,736	1,280 11.00
13.00 01300	NURSING ADMINISTRATION	0	27,100	245,566	272,666	3,161 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	104,814	102,569	207,383	166 14.00
15.00 01500	PHARMACY	0	50,137	3,632	53,769	2,902 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	46,422	9,886	56,308	11 16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	1,043,356	106,042	1,149,398	13,358 30.00
31.00 03100	INTENSIVE CARE UNIT	0	93,621	164,286	257,907	3,249 31.00
40.00 04000	SUBPROVIDER - I/PF	0	99,384	4,552	103,936	1,741 40.00
41.00 04100	SUBPROVIDER - I/RF	0	179,875	34,130	214,005	1,994 41.00
43.00 04300	NURSERY	0	14,273	313	14,586	628 43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
45.00 04500	NURSING FACILITY	0	0	0	0	0 45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	300,232	1,532,205	1,832,437	6,608 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	114,498	0	114,498	1,125 52.00
53.00 05300	ANESTHESIOLOGY	0	8,668	9,822	18,490	66 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	287,499	901,787	1,189,286	4,436 54.00
54.01 05401	FSED RADIOLOGY - DIAGNOSTIC	0	45,485	580,014	625,499	543 54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	142,186	104,675	246,861	1,033 55.00
55.01 05501	WOODLAND CANCER CARE CENTER	0	169,651	1,192,234	1,361,885	1,012 55.01
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MRI	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	68,759	445,791	514,550	1,176 59.00
60.00 06000	LABORATORY	0	142,551	7,643	150,194	0 60.00
60.01 06001	FSED LABORATORY	0	20,639	147	20,786	0 60.01
65.00 06500	RESPIRATORY THERAPY	0	31,800	27,612	59,412	1,318 65.00
66.00 06600	PHYSICAL THERAPY	0	21,909	10,815	32,724	852 66.00
69.00 06900	ELECTROCARDIOLOGY	0	87,858	100,025	187,883	1,207 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00 03950	CV RESOURCE CENTER	0	0	0	0	29 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	0 90.00
90.01 09001	OB CLINIC	0	0	0	0	0 90.01
90.02 09002	PAIN MANAGEMENT	0	0	0	0	0 90.02
90.03 09003	INFUSION OP SERVICES	0	22,115	987	23,102	1,177 90.03
90.04 09004	MATERNAL HEA	0	0	0	0	0 90.04
91.00 09100	EMERGENCY	0	318,981	124,564	443,545	4,995 91.00
91.01 09101	FREE STANDING EMERGENCY DEPT	0	339,446	386,515	725,961	1,844 91.01
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)	0	5,787,387	8,034,545	13,821,932	68,665 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,638	0	15,638	0 190.00
194.00 07950	RETAIL PHARMACY	0	0	0	0	0 194.00
194.01 07951	WORKING WELL	0	0	110,520	110,520	1,565 194.01
194.02 07952	APS DUNELAND SURG ASSOC	0	0	0	0	0 194.02
194.03 07953	MED WATCH	0	96,526	0	96,526	0 194.03
194.04 07954	OCCUPATIONAL MED CENTER	0	0	0	0	0 194.04
194.05 07955	PHYSICIAN PRACTICE	0	0	0	0	0 194.05
194.06 07956	DENTAL SERVICES	0	0	0	0	0 194.06
194.07 07957	DUNELAND MED WATCH	0	0	0	0	0 194.07
194.08 07958	WESTVILLE CLINIC	0	0	0	0	0 194.08
194.09 07959	ORTHOPEDICS	0	0	0	0	0 194.09
194.10 07960	WOMEN SERVICES	0	72,125	0	72,125	0 194.10
194.11 07961	DUNELAND FITNESS CENTER	0	0	30,460	30,460	0 194.11
194.12 07962	CARDIOLOGY ASSOC	0	0	0	0	0 194.12
194.13 07963	DUNELAND FAMILY PRACTICE	0	0	0	0	0 194.13
194.14 07964	ORTHOPEDICS	0	0	0	0	0 194.14

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0015

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

Worksheet B  
Part II  
Date/Time Prepared:  
3/31/2017 12:53 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
	0			2A	4.00	
194.15 07965 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.15
194.16 07966 PHYSICIAN PRACTICE MD WISE	0	0	10,738	10,738	68	194.16
194.17 07967 ENT	0	0	0	0	0	194.17
194.18 07968 SLEEP CLINIC	0	0	0	0	0	194.18
194.19 07969 HEALTH PARTNERS	0	0	5,402	5,402	455	194.19
194.20 07970 CENTER OF HOPE	0	0	462	462	32	194.20
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers				0		201.00
202.00 TOTAL (sum lines 118-201)	0	5,971,676	8,192,127	14,163,803	70,785	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0015

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

Worksheet B  
Part II  
Date/Time Prepared:  
3/31/2017 12:53 pm

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	1,752,254				5.00
7.00	00700	OPERATION OF PLANT	116,280	1,868,029			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,234	28,815	102,554		8.00
9.00	00900	HOUSEKEEPING	29,050	47,308	0	209,627	9.00
10.00	01000	DIETARY	8,427	20,644	41	2,415	101,844
11.00	01100	CAFETERIA	14,582	48,963	0	5,728	0
13.00	01300	NURSING ADMINISTRATION	53,426	11,770	0	1,377	0
14.00	01400	CENTRAL SERVICES & SUPPLY	22,152	45,522	0	5,325	0
15.00	01500	PHARMACY	205,123	21,775	0	2,547	0
16.00	01600	MEDICAL RECORDS & LIBRARY	19,768	20,162	0	2,359	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	186,124	453,147	48,200	53,011	65,179
31.00	03100	INTENSIVE CARE UNIT	42,605	40,661	5,128	4,757	10,580
40.00	04000	SUBPROVIDER - I/PF	25,789	43,164	11,281	5,050	11,177
41.00	04100	SUBPROVIDER - I/RF	30,478	78,123	4,102	9,139	11,015
43.00	04300	NURSERY	8,662	6,199	31	725	3,893
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00	04500	NURSING FACILITY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	106,138	130,395	5,435	15,254	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,743	49,728	0	5,817	0
53.00	05300	ANESTHESIOLOGY	1,704	3,765	0	440	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	78,134	124,865	4,123	14,607	0
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	16,671	19,755	0	2,311	0
55.00	05500	RADIOLOGY-THERAPEUTIC	30,476	61,753	51	7,224	0
55.01	05501	WOODLAND CANCER CARE CENTER	35,304	73,682	1,025	8,620	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	26,735	29,863	31	3,494	0
60.00	06000	LABORATORY	79,600	61,912	0	7,243	0
60.01	06001	FSED LABORATORY	22,980	8,964	0	1,049	0
65.00	06500	RESPIRATORY THERAPY	18,543	13,811	0	1,616	0
66.00	06600	PHYSICAL THERAPY	44,432	9,515	3,077	1,113	0
69.00	06900	ELECTROCARDIOLOGY	19,683	38,158	513	4,464	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	105,111	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	58,321	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03950	CV RESOURCE CENTER	352	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	OB CLINIC	0	0	0	0	0
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0
90.03	09003	INFUSION OP SERVICES	23,248	9,605	31	1,124	0
90.04	09004	MATERNAL HEA	0	0	0	0	0
91.00	09100	EMERGENCY	84,934	138,539	10,255	16,207	0
91.01	09101	FREE STANDING EMERGENCY DEPT	38,859	147,426	4,102	17,247	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,577,668	1,787,989	97,426	200,263	101,844
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	214	6,792	0	795	0
194.00	07950	RETAIL PHARMACY	0	0	0	0	0
194.01	07951	WORKING WELL	24,850	0	5,128	0	0
194.02	07952	APS DUNELAND SURG ASSOC	0	0	0	0	0
194.03	07953	MED WATCH	1,323	41,923	0	4,904	0
194.04	07954	OCCUPATIONAL MED CENTER	0	0	0	0	0
194.05	07955	PHYSICIAN PRACTICE	0	0	0	0	0
194.06	07956	DENTAL SERVICES	0	0	0	0	0
194.07	07957	DUNELAND MED WATCH	0	0	0	0	0
194.08	07958	WESTVILLE CLINIC	0	0	0	0	0
194.09	07959	ORTHOPEDICS	0	0	0	0	0
194.10	07960	WOMEN SERVICES	989	31,325	0	3,665	0
194.11	07961	DUNELAND FITNESS CENTER	420	0	0	0	0
194.12	07962	CARDIOLOGY ASSOC	0	0	0	0	0
194.13	07963	DUNELAND FAMILY PRACTICE	0	0	0	0	0
194.14	07964	ORTHOPEDICS	0	0	0	0	0
194.15	07965	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.16	07966	PHYSICIAN PRACTICE MD WISE	140,769	0	0	0	0
194.17	07967	ENT	0	0	0	0	0
194.18	07968	SLEEP CLINIC	0	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0015			Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 3/31/2017 12:53 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
194.19	07969 HEALTH PARTNERS	5,608	0	0	0	0	0	194.19
194.20	07970 CENTER OF HOPE	413	0	0	0	0	0	194.20
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,752,254	1,868,029	102,554	209,627	101,844		202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0015		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 3/31/2017 12:53 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<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	183,289					11.00
13.00	01300	9,716	352,116				13.00
14.00	01400	1,054	0	281,602			14.00
15.00	01500	7,999	0	0	294,115		15.00
16.00	01600	69	0	0	0	98,677	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	41,602	110,117	0	0	5,949	30.00
31.00	03100	9,249	39,535	0	0	1,033	31.00
40.00	04000	6,178	13,542	0	0	675	40.00
41.00	04100	7,143	14,785	0	0	1,218	41.00
43.00	04300	1,666	7,446	0	0	190	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	26,183	57,621	0	0	17,827	50.00
52.00	05200	2,988	13,358	0	0	340	52.00
53.00	05300	347	0	0	0	757	53.00
54.00	05400	13,744	1,858	0	0	13,325	54.00
54.01	05401	3,211	0	0	0	1,066	54.01
55.00	05500	2,555	1,320	0	0	1,838	55.00
55.01	05501	3,266	5,404	0	0	455	55.01
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	2,964	7,001	0	0	3,035	59.00
60.00	06000	0	0	0	0	8,439	60.00
60.01	06001	0	0	0	0	1,066	60.01
65.00	06500	4,949	0	0	0	2,105	65.00
66.00	06600	3,324	599	0	0	2,917	66.00
69.00	06900	3,960	5,358	0	0	2,397	69.00
71.00	07100	0	0	194,407	0	3,169	71.00
72.00	07200	0	0	87,195	0	2,113	72.00
73.00	07300	0	0	0	294,115	17,618	73.00
76.00	03950	55	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	1,130	4,299	0	0	231	90.03
90.04	09004	0	0	0	0	0	90.04
91.00	09100	16,028	49,085	0	0	7,776	91.00
91.01	09101	5,048	20,681	0	0	1,496	91.01
92.00	09200	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		174,428	352,009	281,602	294,115	98,677	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	8,452	15	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	0	0	0	194.09
194.10	07960	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
194.12	07962	0	0	0	0	0	194.12
194.13	07963	0	0	0	0	0	194.13
194.14	07964	0	0	0	0	0	194.14
194.15	07965	0	0	0	0	0	194.15
194.16	07966	278	0	0	0	0	194.16
194.17	07967	0	0	0	0	0	194.17

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0015			Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 3/31/2017 12:53 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
		11.00	13.00	14.00	15.00	16.00		
194.18	07968 SLEEP CLINIC	0	0	0	0	0	0	194.18
194.19	07969 HEALTH PARTNERS	0	0	0	0	0	0	194.19
194.20	07970 CENTER OF HOPE	131	92	0	0	0	0	194.20
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	183,289	352,116	281,602	294,115	98,677	0	202.00



ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 3/31/2017 12: 53 pm
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<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				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	2,126,085	0	2,126,085	30.00
31.00	03100	414,704	0	414,704	31.00
40.00	04000	222,533	0	222,533	40.00
41.00	04100	372,002	0	372,002	41.00
43.00	04300	44,026	0	44,026	43.00
44.00	04400	0	0	0	44.00
45.00	04500	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	2,197,898	0	2,197,898	50.00
52.00	05200	204,597	0	204,597	52.00
53.00	05300	25,569	0	25,569	53.00
54.00	05400	1,444,378	0	1,444,378	54.00
54.01	05401	670,698	0	670,698	54.01
55.00	05500	353,111	0	353,111	55.00
55.01	05501	1,490,653	0	1,490,653	55.01
57.00	05700	0	0	0	57.00
58.00	05800	0	0	0	58.00
59.00	05900	588,849	0	588,849	59.00
60.00	06000	307,388	0	307,388	60.00
60.01	06001	54,845	0	54,845	60.01
65.00	06500	101,754	0	101,754	65.00
66.00	06600	98,553	0	98,553	66.00
69.00	06900	263,623	0	263,623	69.00
71.00	07100	302,687	0	302,687	71.00
72.00	07200	147,629	0	147,629	72.00
73.00	07300	311,733	0	311,733	73.00
76.00	03950	436	0	436	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	0	0	0	90.00
90.01	09001	0	0	0	90.01
90.02	09002	0	0	0	90.02
90.03	09003	63,947	0	63,947	90.03
90.04	09004	0	0	0	90.04
91.00	09100	771,364	0	771,364	91.00
91.01	09101	962,664	0	962,664	91.01
92.00	09200	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		13,541,726	0	13,541,726	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	23,439	0	23,439	190.00
194.00	07950	0	0	0	194.00
194.01	07951	150,530	0	150,530	194.01
194.02	07952	0	0	0	194.02
194.03	07953	144,676	0	144,676	194.03
194.04	07954	0	0	0	194.04
194.05	07955	0	0	0	194.05
194.06	07956	0	0	0	194.06
194.07	07957	0	0	0	194.07
194.08	07958	0	0	0	194.08
194.09	07959	0	0	0	194.09
194.10	07960	108,104	0	108,104	194.10
194.11	07961	30,880	0	30,880	194.11
194.12	07962	0	0	0	194.12
194.13	07963	0	0	0	194.13
194.14	07964	0	0	0	194.14
194.15	07965	0	0	0	194.15

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0015

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

Worksheet B  
Part II  
Date/Time Prepared:  
3/31/2017 12:53 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
194.16	07966 PHYSICIAN PRACTICE MD WISE	151,853	0	151,853	194.16
194.17	07967 ENT	0	0	0	194.17
194.18	07968 SLEEP CLINIC	0	0	0	194.18
194.19	07969 HEALTH PARTNERS	11,465	0	11,465	194.19
194.20	07970 CENTER OF HOPE	1,130	0	1,130	194.20
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	14,163,803	0	14,163,803	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0015

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

Worksheet B-1  
Date/Time Prepared:  
3/31/2017 12:53 pm

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				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	376,144				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		8,003,439			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,625	12,929	45,781,532		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	54,268	863,389	4,494,789	-29,680,109	127,842,560
7.00 00700	OPERATION OF PLANT	47,334	973,900	2,206,886	0	8,483,911
8.00 00800	LAUNDRY & LINEN SERVICE	4,179	155	0	0	527,796
9.00 00900	HOUSEKEEPING	6,861	21,931	1,226,084	0	2,119,524
10.00 01000	DIETARY	2,994	21,774	321,286	0	614,840
11.00 01100	CAFETERIA	7,101	0	827,985	0	1,063,945
13.00 01300	NURSING ADMINISTRATION	1,707	239,910	2,044,932	0	3,897,994
14.00 01400	CENTRAL SERVICES & SUPPLY	6,602	100,207	107,582	0	1,616,225
15.00 01500	PHARMACY	3,158	3,548	1,876,952	0	14,962,823
16.00 01600	MEDICAL RECORDS & LIBRARY	2,924	9,658	6,877	0	1,442,276
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	65,719	103,600	8,635,240	0	13,579,750
31.00 03100	INTENSIVE CARE UNIT	5,897	160,502	2,101,552	0	3,108,492
40.00 04000	SUBPROVIDER - IPF	6,260	4,447	1,126,186	0	1,881,564
41.00 04100	SUBPROVIDER - IRF	11,330	33,344	1,289,550	0	2,223,664
43.00 04300	NURSERY	899	306	405,903	0	631,974
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00 04500	NURSING FACILITY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	18,911	1,496,915	4,274,565	0	7,743,930
52.00 05200	DELIVERY ROOM & LABOR ROOM	7,212	0	727,836	0	1,221,554
53.00 05300	ANESTHESIOLOGY	546	9,596	42,734	0	124,344
54.00 05400	RADIOLOGY-DIAGNOSTIC	18,109	881,016	2,869,513	0	5,700,716
54.01 05401	FSED RADIOLOGY - DIAGNOSTIC	2,865	566,655	351,469	0	1,216,355
55.00 05500	RADIOLOGY-THERAPEUTIC	8,956	102,264	668,161	0	2,223,557
55.01 05501	WOODLAND CANCER CARE CENTER	10,686	1,164,773	654,895	0	2,575,788
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MRI	0	0	0	0	0
59.00 05900	CARDIAC CATHETERIZATION	4,331	435,523	760,769	0	1,950,575
60.00 06000	LABORATORY	8,979	7,467	0	0	5,807,668
60.01 06001	FSED LABORATORY	1,300	144	0	0	1,676,641
65.00 06500	RESPIRATORY THERAPY	2,003	26,976	852,380	0	1,352,887
66.00 06600	PHYSICAL THERAPY	1,380	10,566	551,346	0	3,241,775
69.00 06900	ELECTROCARDIOLOGY	5,534	97,721	780,461	0	1,436,114
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	7,668,955
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,255,169
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	180,616	0
76.00 03950	CV RESOURCE CENTER	0	0	18,991	0	25,677
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	0
90.01 09001	OB CLINIC	0	0	0	0	0
90.02 09002	PAIN MANAGEMENT	0	0	0	0	0
90.03 09003	INFUSION OP SERVICES	1,393	964	761,415	0	1,696,161
90.04 09004	MATERNAL HEA	0	0	0	0	0
91.00 09100	EMERGENCY	20,092	121,695	3,231,210	0	6,196,844
91.01 09101	FREE STANDING EMERGENCY DEPT	21,381	377,612	1,192,993	0	2,835,195
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)	364,536	7,849,487	44,410,542	-29,499,493	115,104,683
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	985	0	0	0	15,638
194.00 07950	RETAIL PHARMACY	0	0	0	0	0
194.01 07951	WORKING WELL	0	107,974	1,012,584	0	1,813,105
194.02 07952	APS DUNELAND SURG ASSOC	0	0	0	0	0
194.03 07953	MED WATCH	6,080	0	0	0	96,526
194.04 07954	OCCUPATIONAL MED CENTER	0	0	0	0	0
194.05 07955	PHYSICIAN PRACTICE	0	0	0	0	0
194.06 07956	DENTAL SERVICES	0	0	0	0	0
194.07 07957	DUNELAND MED WATCH	0	0	0	0	0
194.08 07958	WESTVILLE CLNIC	0	0	0	0	0
194.09 07959	ORTHOPEDICS	0	0	0	0	0
194.10 07960	WOMEN SERVICES	4,543	0	0	0	72,125
194.11 07961	DUNELAND FITNESS CENTER	0	29,758	0	0	30,613
194.12 07962	CARDIOLOGY ASSOC	0	0	0	0	0
194.13 07963	DUNELAND FAMILY PRACTICE	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0015

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

Worksheet B-1

Date/Time Prepared:  
3/31/2017 12:53 pm

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				
194.14 07964 ORTHOPEDICS	0	0	0	0	0	194.14
194.15 07965 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.15
194.16 07966 PHYSICIAN PRACTICE MD WISE	0	10,491	43,952	0	10,270,598	194.16
194.17 07967 ENT	0	0	0	0	0	194.17
194.18 07968 SLEEP CLINIC	0	0	0	0	0	194.18
194.19 07969 HEALTH PARTNERS	0	5,278	294,005	0	409,161	194.19
194.20 07970 CENTER OF HOPE	0	451	20,449	0	30,111	194.20
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)	5,971,676	8,192,127	16,118,587		29,680,109	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	15.876037	1.023576	0.352076		0.232161	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			70,785		1,752,254	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.001546		0.013706	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0015

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

Worksheet B-1

Date/Time Prepared:  
3/31/2017 12:53 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
<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	270,917					7.00
8.00	00800	4,179	712,242				8.00
9.00	00900	6,861	0	259,877			9.00
10.00	01000	2,994	285	2,994	116,291		10.00
11.00	01100	7,101	0	7,101	0	53,370	11.00
13.00	01300	1,707	0	1,707	0	2,829	13.00
14.00	01400	6,602	0	6,602	0	307	14.00
15.00	01500	3,158	0	3,158	0	2,329	15.00
16.00	01600	2,924	0	2,924	0	20	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	65,719	334,753	65,719	74,425	12,114	30.00
31.00	03100	5,897	35,612	5,897	12,081	2,693	31.00
40.00	04000	6,260	78,347	6,260	12,763	1,799	40.00
41.00	04100	11,330	28,490	11,330	12,577	2,080	41.00
43.00	04300	899	214	899	4,445	485	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	18,911	37,749	18,911	0	7,624	50.00
52.00	05200	7,212	0	7,212	0	870	52.00
53.00	05300	546	0	546	0	101	53.00
54.00	05400	18,109	28,632	18,109	0	4,002	54.00
54.01	05401	2,865	0	2,865	0	935	54.01
55.00	05500	8,956	356	8,956	0	744	55.00
55.01	05501	10,686	7,122	10,686	0	951	55.01
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	4,331	214	4,331	0	863	59.00
60.00	06000	8,979	0	8,979	0	0	60.00
60.01	06001	1,300	0	1,300	0	0	60.01
65.00	06500	2,003	0	2,003	0	1,441	65.00
66.00	06600	1,380	21,367	1,380	0	968	66.00
69.00	06900	5,534	3,561	5,534	0	1,153	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03950	0	0	0	0	16	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	1,393	214	1,393	0	329	90.03
90.04	09004	0	0	0	0	0	90.04
91.00	09100	20,092	71,224	20,092	0	4,667	91.00
91.01	09101	21,381	28,490	21,381	0	1,470	91.01
92.00	09200	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		259,309	676,630	248,269	116,291	50,790	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	985	0	985	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	35,612	0	0	2,461	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	6,080	0	6,080	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	0	0	0	194.09
194.10	07960	4,543	0	4,543	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
194.12	07962	0	0	0	0	0	194.12
194.13	07963	0	0	0	0	0	194.13
194.14	07964	0	0	0	0	0	194.14
194.15	07965	0	0	0	0	0	194.15
194.16	07966	0	0	0	0	81	194.16

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0015

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

Worksheet B-1

Date/Time Prepared:  
3/31/2017 12:53 pm

Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
	7.00	8.00	9.00	10.00	11.00	
194.17 07967 ENT	0	0	0	0	0	194.17
194.18 07968 SLEEP CLINIC	0	0	0	0	0	194.18
194.19 07969 HEALTH PARTNERS	0	0	0	0	0	194.19
194.20 07970 CENTER OF HOPE	0	0	0	0	38	194.20
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)	10,453,544	811,580	2,876,332	906,571	1,663,544	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	38.585781	1.139472	11.068051	7.795711	31.170021	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	1,868,029	102,554	209,627	101,844	183,289	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	6.895208	0.143988	0.806639	0.875769	3.434308	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0015

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

Worksheet B-1

Date/Time Prepared:  
3/31/2017 12:53 pm

Cost Center Description		NURSING ADMINISTRATION  (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)		
		13.00	14.00	15.00	16.00		
<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						11.00
13.00	01300	22,934					13.00
14.00	01400	0	11,308,609				14.00
15.00	01500	0	0	100			15.00
16.00	01600	0	0	0	622,128,778		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	7,172	0	0	37,413,794		30.00
31.00	03100	2,575	0	0	6,494,828		31.00
40.00	04000	882	0	0	4,242,765		40.00
41.00	04100	963	0	0	7,657,275		41.00
43.00	04300	485	0	0	1,193,594		43.00
44.00	04400	0	0	0	0		44.00
45.00	04500	0	0	0	0		45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	3,753	0	0	113,644,660		50.00
52.00	05200	870	0	0	2,140,267		52.00
53.00	05300	0	0	0	4,762,962		53.00
54.00	05400	121	0	0	83,806,212		54.00
54.01	05401	0	0	0	17,034,520		54.01
55.00	05500	86	0	0	11,557,647		55.00
55.01	05501	352	0	0	2,860,374		55.01
57.00	05700	0	0	0	0		57.00
58.00	05800	0	0	0	0		58.00
59.00	05900	456	0	0	19,090,555		59.00
60.00	06000	0	0	0	53,073,022		60.00
60.01	06001	0	0	0	6,704,085		60.01
65.00	06500	0	0	0	13,240,068		65.00
66.00	06600	39	0	0	18,346,226		66.00
69.00	06900	349	0	0	15,078,174		69.00
71.00	07100	0	7,807,084	0	19,929,286		71.00
72.00	07200	0	3,501,525	0	13,287,219		72.00
73.00	07300	0	0	100	110,804,654		73.00
76.00	03950	0	0	0	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0		90.00
90.01	09001	0	0	0	0		90.01
90.02	09002	0	0	0	0		90.02
90.03	09003	280	0	0	1,451,837		90.03
90.04	09004	0	0	0	0		90.04
91.00	09100	3,197	0	0	48,907,225		91.00
91.01	09101	1,347	0	0	9,407,529		91.01
92.00	09200	0	0	0	0		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		22,927	11,308,609	100	622,128,778		118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0		190.00
194.00	07950	0	0	0	0		194.00
194.01	07951	1	0	0	0		194.01
194.02	07952	0	0	0	0		194.02
194.03	07953	0	0	0	0		194.03
194.04	07954	0	0	0	0		194.04
194.05	07955	0	0	0	0		194.05
194.06	07956	0	0	0	0		194.06
194.07	07957	0	0	0	0		194.07
194.08	07958	0	0	0	0		194.08
194.09	07959	0	0	0	0		194.09
194.10	07960	0	0	0	0		194.10
194.11	07961	0	0	0	0		194.11
194.12	07962	0	0	0	0		194.12
194.13	07963	0	0	0	0		194.13
194.14	07964	0	0	0	0		194.14
194.15	07965	0	0	0	0		194.15

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0015

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

Worksheet B-1

Date/Time Prepared:  
3/31/2017 12:53 pm

Cost Center Description		NURSING ADMINISTRATION  (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)		
		13.00	14.00	15.00	16.00		
194.16	07966	PHYSICIAN PRACTICE MD WISE	0	0	0	0	194.16
194.17	07967	ENT	0	0	0	0	194.17
194.18	07968	SLEEP CLINIC	0	0	0	0	194.18
194.19	07969	HEALTH PARTNERS	0	0	0	0	194.19
194.20	07970	CENTER OF HOPE	6	0	0	0	194.20
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)	4,975,895	2,328,832	18,666,060	1,922,927	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	216.965859	0.205934	186,660.600000	0.003091	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	352,116	281,602	294,115	98,677	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	15.353449	0.024902	2,941.150000	0.000159	205.00



COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0015

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

Worksheet C  
Part I  
Date/Time Prepared:  
3/31/2017 12:53 pm

		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	23,006,593		23,006,593	8,529	23,015,122	30.00
31.00	03100	INTENSIVE CARE UNIT	4,920,434		4,920,434	0	4,920,434	31.00
40.00	04000	SUBPROVIDER - I/PF	3,078,547		3,078,547	3,544	3,082,091	40.00
41.00	04100	SUBPROVIDER - I/RF	3,730,442		3,730,442	0	3,730,442	41.00
43.00	04300	NURSERY	982,263		982,263	0	982,263	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	11,926,902		11,926,902	93,374	12,020,276	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,085,749		2,085,749	0	2,085,749	52.00
53.00	05300	ANESTHESIOLOGY	198,193		198,193	2,284	200,477	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,366,046		8,366,046	0	8,366,046	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	1,722,801		1,722,801	0	1,722,801	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	3,262,459		3,262,459	0	3,262,459	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	3,827,358		3,827,358	0	3,827,358	55.01
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,803,562		2,803,562	6,550	2,810,112	59.00
60.00	06000	LABORATORY	7,765,873		7,765,873	16,151	7,782,024	60.00
60.01	06001	FSED LABORATORY	2,151,164		2,151,164	0	2,151,164	60.01
65.00	06500	RESPIRATORY THERAPY	1,852,272	0	1,852,272	0	1,852,272	65.00
66.00	06600	PHYSICAL THERAPY	4,182,601	0	4,182,601	21,121	4,203,722	66.00
69.00	06900	ELECTROCARDIOLOGY	2,206,634		2,206,634	0	2,206,634	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,118,737		11,118,737	0	11,118,737	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,005,207		6,005,207	0	6,005,207	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,827,941		18,827,941	0	18,827,941	73.00
76.00	03950	CV RESOURCE CENTER	32,137		32,137	0	32,137	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	OB CLINIC	0		0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0		0	0	0	90.02
90.03	09003	INFUSION OP SERVICES	2,234,848		2,234,848	0	2,234,848	90.03
90.04	09004	MATERNAL HEA	0		0	0	0	90.04
91.00	09100	EMERGENCY	9,704,594		9,704,594	0	9,704,594	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	4,954,682		4,954,682	0	4,954,682	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,486,028		3,486,028	0	3,486,028	92.00
200.00		Subtotal (see instructions)	144,434,067	0	144,434,067	151,553	144,585,620	200.00
201.00		Less Observation Beds	3,486,028		3,486,028	0	3,486,028	201.00
202.00		Total (see instructions)	140,948,039	0	140,948,039	151,553	141,099,592	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 3/31/2017 12:53 pm
		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	33,068,067		33,068,067	30.00
31.00	03100	INTENSIVE CARE UNIT	6,494,828		6,494,828	31.00
40.00	04000	SUBPROVIDER - IPF	4,242,765		4,242,765	40.00
41.00	04100	SUBPROVIDER - IRF	7,657,275		7,657,275	41.00
43.00	04300	NURSERY	1,193,594		1,193,594	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	44.00
45.00	04500	NURSING FACILITY	0		0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	28,893,377	84,751,283	113,644,660	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,955,557	184,710	2,140,267	52.00
53.00	05300	ANESTHESIOLOGY	1,857,589	2,905,373	4,762,962	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,414,155	65,392,057	83,806,212	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	1,076,984	15,957,536	17,034,520	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,326,195	10,231,452	11,557,647	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	26,925	2,833,449	2,860,374	55.01
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,899,366	11,191,189	19,090,555	59.00
60.00	06000	LABORATORY	20,187,257	32,885,765	53,073,022	60.00
60.01	06001	FSED LABORATORY	62,407	6,641,678	6,704,085	60.01
65.00	06500	RESPIRATORY THERAPY	12,008,632	1,231,436	13,240,068	65.00
66.00	06600	PHYSICAL THERAPY	4,791,234	13,554,992	18,346,226	66.00
69.00	06900	ELECTROCARDIOLOGY	5,611,561	9,466,613	15,078,174	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,103,008	9,826,278	19,929,286	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,513,229	3,773,990	13,287,219	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,847,309	75,957,345	110,804,654	73.00
76.00	03950	CV RESOURCE CENTER	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	0	0	90.00
90.01	09001	OB CLINIC	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	90.02
90.03	09003	INFUSION OP SERVICES	19,922	1,431,915	1,451,837	90.03
90.04	09004	MATERNAL HEA	0	0	0	90.04
91.00	09100	EMERGENCY	9,850,046	39,057,179	48,907,225	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	1,151,746	8,255,783	9,407,529	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	590,643	3,755,084	4,345,727	92.00
200.00		Subtotal (see instructions)	222,843,671	399,285,107	622,128,778	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	222,843,671	399,285,107	622,128,778	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 3/31/2017 12:53 pm
		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
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
45.00	04500 NURSING FACILITY			45.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.105771		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.974527		52.00
53.00	05300 ANESTHESIOLOGY	0.042091		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.099826		54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0.101136		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.282277		55.00
55.01	05501 WOODLAND CANCER CARE CENTER	1.338062		55.01
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.147199		59.00
60.00	06000 LABORATORY	0.146629		60.00
60.01	06001 FSED LABORATORY	0.320874		60.01
65.00	06500 RESPIRATORY THERAPY	0.139899		65.00
66.00	06600 PHYSICAL THERAPY	0.229133		66.00
69.00	06900 ELECTROCARDIOLOGY	0.146346		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.557909		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.451954		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.169920		73.00
76.00	03950 CV RESOURCE CENTER	0.000000		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 OB CLINIC	0.000000		90.01
90.02	09002 PAIN MANAGEMENT	0.000000		90.02
90.03	09003 INFUSION OP SERVICES	1.539324		90.03
90.04	09004 MATERNAL HEA	0.000000		90.04
91.00	09100 EMERGENCY	0.198429		91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0.526672		91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.802174		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: 15-0015

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

Worksheet C  
Part I  
Date/Time Prepared:  
3/31/2017 12:53 pm

		Title XIX		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total 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	23,006,593		23,006,593	8,529	23,015,122	30.00
31.00	03100 INTENSIVE CARE UNIT	4,920,434		4,920,434	0	4,920,434	31.00
40.00	04000 SUBPROVIDER - I/PF	3,078,547		3,078,547	3,544	3,082,091	40.00
41.00	04100 SUBPROVIDER - I/RF	3,730,442		3,730,442	0	3,730,442	41.00
43.00	04300 NURSERY	982,263		982,263	0	982,263	43.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500 NURSING FACILITY	0		0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	11,926,902		11,926,902	93,374	12,020,276	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,085,749		2,085,749	0	2,085,749	52.00
53.00	05300 ANESTHESIOLOGY	198,193		198,193	2,284	200,477	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,366,046		8,366,046	0	8,366,046	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	1,722,801		1,722,801	0	1,722,801	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	3,262,459		3,262,459	0	3,262,459	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	3,827,358		3,827,358	0	3,827,358	55.01
57.00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MRI	0		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	2,803,562		2,803,562	6,550	2,810,112	59.00
60.00	06000 LABORATORY	7,765,873		7,765,873	16,151	7,782,024	60.00
60.01	06001 FSED LABORATORY	2,151,164		2,151,164	0	2,151,164	60.01
65.00	06500 RESPIRATORY THERAPY	1,852,272	0	1,852,272	0	1,852,272	65.00
66.00	06600 PHYSICAL THERAPY	4,182,601	0	4,182,601	21,121	4,203,722	66.00
69.00	06900 ELECTROCARDIOLOGY	2,206,634		2,206,634	0	2,206,634	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	11,118,737		11,118,737	0	11,118,737	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	6,005,207		6,005,207	0	6,005,207	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	18,827,941		18,827,941	0	18,827,941	73.00
76.00	03950 CV RESOURCE CENTER	32,137		32,137	0	32,137	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0		0	0	0	90.00
90.01	09001 OB CLINIC	0		0	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0		0	0	0	90.02
90.03	09003 INFUSION OP SERVICES	2,234,848		2,234,848	0	2,234,848	90.03
90.04	09004 MATERNAL HEA	0		0	0	0	90.04
91.00	09100 EMERGENCY	9,704,594		9,704,594	0	9,704,594	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	4,954,682		4,954,682	0	4,954,682	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3,486,028		3,486,028		3,486,028	92.00
200.00	Subtotal (see instructions)	144,434,067	0	144,434,067	151,553	144,585,620	200.00
201.00	Less Observation Beds	3,486,028		3,486,028		3,486,028	201.00
202.00	Total (see instructions)	140,948,039	0	140,948,039	151,553	141,099,592	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 3/31/2017 12:53 pm
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Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	33,068,067		33,068,067			30.00
31.00 03100 INTENSIVE CARE UNIT	6,494,828		6,494,828			31.00
40.00 04000 SUBPROVIDER - IPF	4,242,765		4,242,765			40.00
41.00 04100 SUBPROVIDER - IRF	7,657,275		7,657,275			41.00
43.00 04300 NURSERY	1,193,594		1,193,594			43.00
44.00 04400 SKILLED NURSING FACILITY	0		0			44.00
45.00 04500 NURSING FACILITY	0		0			45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	28,893,377	84,751,283	113,644,660	0.104949	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1,955,557	184,710	2,140,267	0.974527	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	1,857,589	2,905,373	4,762,962	0.041611	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	18,414,155	65,392,057	83,806,212	0.099826	0.000000	54.00
54.01 05401 FSED RADIOLOGY - DIAGNOSTIC	1,076,984	15,957,536	17,034,520	0.101136	0.000000	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	1,326,195	10,231,452	11,557,647	0.282277	0.000000	55.00
55.01 05501 WOODLAND CANCER CARE CENTER	26,925	2,833,449	2,860,374	1.338062	0.000000	55.01
57.00 05700 CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00 05800 MRI	0	0	0	0.000000	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	7,899,366	11,191,189	19,090,555	0.146856	0.000000	59.00
60.00 06000 LABORATORY	20,187,257	32,885,765	53,073,022	0.146324	0.000000	60.00
60.01 06001 FSED LABORATORY	62,407	6,641,678	6,704,085	0.320874	0.000000	60.01
65.00 06500 RESPIRATORY THERAPY	12,008,632	1,231,436	13,240,068	0.139899	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	4,791,234	13,554,992	18,346,226	0.227982	0.000000	66.00
69.00 06900 ELECTROCARDIOLOGY	5,611,561	9,466,613	15,078,174	0.146346	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10,103,008	9,826,278	19,929,286	0.557909	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	9,513,229	3,773,990	13,287,219	0.451954	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	34,847,309	75,957,345	110,804,654	0.169920	0.000000	73.00
76.00 03950 CV RESOURCE CENTER	0	0	0	0.000000	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0.000000	0.000000	90.00
90.01 09001 OB CLINIC	0	0	0	0.000000	0.000000	90.01
90.02 09002 PAIN MANAGEMENT	0	0	0	0.000000	0.000000	90.02
90.03 09003 INFUSION OP SERVICES	19,922	1,431,915	1,451,837	1.539324	0.000000	90.03
90.04 09004 MATERNAL HEA	0	0	0	0.000000	0.000000	90.04
91.00 09100 EMERGENCY	9,850,046	39,057,179	48,907,225	0.198429	0.000000	91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	1,151,746	8,255,783	9,407,529	0.526672	0.000000	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	590,643	3,755,084	4,345,727	0.802174	0.000000	92.00
200.00 Subtotal (see instructions)	222,843,671	399,285,107	622,128,778			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	222,843,671	399,285,107	622,128,778			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 3/31/2017 12:53 pm
		Title XIX	Hospital	Cost

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
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
45.00	04500 NURSING FACILITY			45.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0.000000		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
55.01	05501 WOODLAND CANCER CARE CENTER	0.000000		55.01
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 FSED LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950 CV RESOURCE CENTER	0.000000		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 OB CLINIC	0.000000		90.01
90.02	09002 PAIN MANAGEMENT	0.000000		90.02
90.03	09003 INFUSION OP SERVICES	0.000000		90.03
90.04	09004 MATERNAL HEA	0.000000		90.04
91.00	09100 EMERGENCY	0.000000		91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0.000000		91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part I Date/Time Prepared: 3/31/2017 12:53 pm
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Cost Center Description		Title XVIII			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,126,085	0	2,126,085	20,341	104.52	30.00
31.00	INTENSIVE CARE UNIT	414,704	0	414,704	2,995	138.47	31.00
40.00	SUBPROVIDER - IPF	222,533	0	222,533	3,164	70.33	40.00
41.00	SUBPROVIDER - IRF	372,002	0	372,002	3,118	119.31	41.00
43.00	NURSERY	44,026	0	44,026	1,102	39.95	43.00
44.00	SKILLED NURSING FACILITY	0	0	0	0	0.00	44.00
45.00	NURSING FACILITY	0	0	0	0	0.00	45.00
200.00	Total (Lines 30-199)	3,179,350		3,179,350	30,720		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	10,053	1,050,740				30.00
31.00	INTENSIVE CARE UNIT	1,456	201,612				31.00
40.00	SUBPROVIDER - IPF	986	69,345				40.00
41.00	SUBPROVIDER - IRF	2,361	281,691				41.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
45.00	NURSING FACILITY	0	0				45.00
200.00	Total (Lines 30-199)	14,856	1,603,388				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Prepared: 3/31/2017 12:53 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,197,898	113,644,660	0.019340	12,971,877	250,876	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	204,597	2,140,267	0.095594	5,333	510	52.00
53.00	05300 ANESTHESIOLOGY	25,569	4,762,962	0.005368	830,046	4,456	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,444,378	83,806,212	0.017235	10,824,721	186,564	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	670,698	17,034,520	0.039373	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	353,111	11,557,647	0.030552	888,368	27,141	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	1,490,653	2,860,374	0.521139	0	0	55.01
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MRI	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	588,849	19,090,555	0.030845	4,151,529	128,054	59.00
60.00	06000 LABORATORY	307,388	53,073,022	0.005792	10,642,415	61,641	60.00
60.01	06001 FSED LABORATORY	54,845	6,704,085	0.008181	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	101,754	13,240,068	0.007685	6,891,649	52,962	65.00
66.00	06600 PHYSICAL THERAPY	98,553	18,346,226	0.005372	1,609,589	8,647	66.00
69.00	06900 ELECTROCARDIOLOGY	263,623	15,078,174	0.017484	3,104,758	54,284	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	302,687	19,929,286	0.015188	4,206,133	63,883	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	147,629	13,287,219	0.011111	4,703,628	52,262	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	311,733	110,804,654	0.002813	18,799,977	52,884	73.00
76.00	03950 CV RESOURCE CENTER	436	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.01	09001 OB CLINIC	0	0	0.000000	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0	0	0.000000	0	0	90.02
90.03	09003 INFUSION OP SERVICES	63,947	1,451,837	0.044046	18,471	814	90.03
90.04	09004 MATERNAL HEA	0	0	0.000000	0	0	90.04
91.00	09100 EMERGENCY	771,364	48,907,225	0.015772	4,101,009	64,681	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	962,664	9,407,529	0.102329	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	322,032	4,345,727	0.074103	587,473	43,534	92.00
200.00	Total (lines 50-199)	10,684,408	569,472,249		84,336,976	1,053,193	200.00



APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part III Date/Time Prepared: 3/31/2017 12:53 pm
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Cost Center Description			Title XVIII				Hospital	
			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)	PPS
			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
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
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	20,341	0.00	10,053	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,995	0.00	1,456	0		31.00
40.00	04000	SUBPROVIDER - IPF	3,164	0.00	986	0		40.00
41.00	04100	SUBPROVIDER - IRF	3,118	0.00	2,361	0		41.00
43.00	04300	NURSERY	1,102	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
45.00	04500	NURSING FACILITY	0	0.00	0	0		45.00
200.00		Total (lines 30-199)	30,720		14,856	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 3/31/2017 12:53 pm
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Cost Center Description		Title XVIII				Hospital	PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	0	0	0	0	55.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	FSED LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	CV RESOURCE CENTER	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	OB CLINIC	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	90.02
90.03	09003	INFUSION OP SERVICES	0	0	0	0	90.03
90.04	09004	MATERNAL HEA	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (Lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0015

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

Worksheet D  
Part IV  
Date/Time Prepared:  
3/31/2017 12:53 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	113,644,660	0.000000	0.000000	12,971,877	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,140,267	0.000000	0.000000	5,333	52.00
53.00	05300	ANESTHESIOLOGY	0	4,762,962	0.000000	0.000000	830,046	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	83,806,212	0.000000	0.000000	10,824,721	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	0	17,034,520	0.000000	0.000000	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	11,557,647	0.000000	0.000000	888,368	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	0	2,860,374	0.000000	0.000000	0	55.01
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	19,090,555	0.000000	0.000000	4,151,529	59.00
60.00	06000	LABORATORY	0	53,073,022	0.000000	0.000000	10,642,415	60.00
60.01	06001	FSED LABORATORY	0	6,704,085	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	13,240,068	0.000000	0.000000	6,891,649	65.00
66.00	06600	PHYSICAL THERAPY	0	18,346,226	0.000000	0.000000	1,609,589	66.00
69.00	06900	ELECTROCARDIOLOGY	0	15,078,174	0.000000	0.000000	3,104,758	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	19,929,286	0.000000	0.000000	4,206,133	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,287,219	0.000000	0.000000	4,703,628	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	110,804,654	0.000000	0.000000	18,799,977	73.00
76.00	03950	CV RESOURCE CENTER	0	0	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	OB CLINIC	0	0	0.000000	0.000000	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0.000000	0.000000	0	90.02
90.03	09003	INFUSION OP SERVICES	0	1,451,837	0.000000	0.000000	18,471	90.03
90.04	09004	MATERNAL HEA	0	0	0.000000	0.000000	0	90.04
91.00	09100	EMERGENCY	0	48,907,225	0.000000	0.000000	4,101,009	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	0	9,407,529	0.000000	0.000000	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,345,727	0.000000	0.000000	587,473	92.00
200.00		Total (lines 50-199)	0	569,472,249			84,336,976	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 3/31/2017 12:53 pm
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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	27,812,205	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	808,102	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	19,260,752	0		54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0	3,291,851	0		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	4,911,401	0		55.00
55.01	05501 WOODLAND CANCER CARE CENTER	0	971,809	0		55.01
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MRI	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	6,093,651	0		59.00
60.00	06000 LABORATORY	0	6,256,395	0		60.00
60.01	06001 FSED LABORATORY	0	0	0		60.01
65.00	06500 RESPIRATORY THERAPY	0	330,575	0		65.00
66.00	06600 PHYSICAL THERAPY	0	47,963	0		66.00
69.00	06900 ELECTROCARDIOLOGY	0	3,508,562	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,871,414	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2,188,137	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	26,189,537	0		73.00
76.00	03950 CV RESOURCE CENTER	0	0	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0	0	0		90.00
90.01	09001 OB CLINIC	0	0	0		90.01
90.02	09002 PAIN MANAGEMENT	0	0	0		90.02
90.03	09003 INFUSION OP SERVICES	0	2,299,947	0		90.03
90.04	09004 MATERNAL HEA	0	0	0		90.04
91.00	09100 EMERGENCY	0	7,753,558	0		91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0	0	0		91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1,106,357	0		92.00
200.00	Total (lines 50-199)	0	114,702,216	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 3/31/2017 12:53 pm
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		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	0.104949	27,812,205	0	0	2,918,863	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.974527	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.041611	808,102	0	0	33,626	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.099826	19,260,752	0	0	1,922,724	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	0.101136	3,291,851	0	0	332,925	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.282277	4,911,401	0	0	1,386,376	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	1.338062	971,809	0	0	1,300,341	55.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.146856	6,093,651	0	0	894,889	59.00
60.00	06000	LABORATORY	0.146324	6,256,395	355	0	915,461	60.00
60.01	06001	FSED LABORATORY	0.320874	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.139899	330,575	0	0	46,247	65.00
66.00	06600	PHYSICAL THERAPY	0.227982	47,963	0	0	10,935	66.00
69.00	06900	ELECTROCARDIOLOGY	0.146346	3,508,562	0	0	513,464	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.557909	1,871,414	0	0	1,044,079	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.451954	2,188,137	0	0	988,937	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.169920	26,189,537	0	23,385	4,450,126	73.00
76.00	03950	CV RESOURCE CENTER	0.000000	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OB CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	0	0	0	90.02
90.03	09003	INFUSION OP SERVICES	1.539324	2,299,947	0	0	3,540,364	90.03
90.04	09004	MATERNAL HEA	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.198429	7,753,558	0	0	1,538,531	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	0.526672	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.802174	1,106,357	0	0	887,491	92.00
200.00		Subtotal (see instructions)		114,702,216	355	23,385	22,725,379	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		114,702,216	355	23,385	22,725,379	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 3/31/2017 12:53 pm
		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
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 05401 FSED RADIOLOGY - DIAGNOSTIC	0	0		54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01 05501 WOODLAND CANCER CARE CENTER	0	0		55.01
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	52	0		60.00
60.01 06001 FSED LABORATORY	0	0		60.01
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3,974		73.00
76.00 03950 CV RESOURCE CENTER	0	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 OB CLINIC	0	0		90.01
90.02 09002 PAIN MANAGEMENT	0	0		90.02
90.03 09003 INFUSION OP SERVICES	0	0		90.03
90.04 09004 MATERNAL HEA	0	0		90.04
91.00 09100 EMERGENCY	0	0		91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	0	0		91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	52	3,974		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	52	3,974		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-0015 Component CCN: 15-S015	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Prepared: 3/31/2017 12:53 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	2,197,898	113,644,660	0.019340	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	204,597	2,140,267	0.095594	0	0	52.00
53.00	05300 ANESTHESIOLOGY	25,569	4,762,962	0.005368	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,444,378	83,806,212	0.017235	34,961	603	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	670,698	17,034,520	0.039373	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	353,111	11,557,647	0.030552	0	0	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	1,490,653	2,860,374	0.521139	0	0	55.01
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MRI	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	588,849	19,090,555	0.030845	0	0	59.00
60.00	06000 LABORATORY	307,388	53,073,022	0.005792	114,897	665	60.00
60.01	06001 FSED LABORATORY	54,845	6,704,085	0.008181	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	101,754	13,240,068	0.007685	21,896	168	65.00
66.00	06600 PHYSICAL THERAPY	98,553	18,346,226	0.005372	7,702	41	66.00
69.00	06900 ELECTROCARDIOLOGY	263,623	15,078,174	0.017484	4,384	77	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	302,687	19,929,286	0.015188	12,127	184	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	147,629	13,287,219	0.011111	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	311,733	110,804,654	0.002813	260,715	733	73.00
76.00	03950 CV RESOURCE CENTER	436	0	0.000000	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.01	09001 OB CLINIC	0	0	0.000000	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0	0	0.000000	0	0	90.02
90.03	09003 INFUSION OP SERVICES	63,947	1,451,837	0.044046	0	0	90.03
90.04	09004 MATERNAL HEA	0	0	0.000000	0	0	90.04
91.00	09100 EMERGENCY	771,364	48,907,225	0.015772	112,274	1,771	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	962,664	9,407,529	0.102329	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	4,345,727	0.000000	0	0	92.00
200.00	Total (lines 50-199)	10,362,376	569,472,249		568,956	4,242	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0015 Component CCN: 15-S015	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 3/31/2017 12:53 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	0	0	0	0	0 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0 55.00
55.01	05501	WOODLAND CANCER CARE CENTER	0	0	0	0	0 55.01
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	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
60.01	06001	FSED LABORATORY	0	0	0	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03950	CV RESOURCE CENTER	0	0	0	0	0 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.01	09001	OB CLINIC	0	0	0	0	0 90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0 90.02
90.03	09003	INFUSION OP SERVICES	0	0	0	0	0 90.03
90.04	09004	MATERNAL HEA	0	0	0	0	0 90.04
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	0	0	0	0	0 91.01
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: 15-0015 Component CCN: 15-S015	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 3/31/2017 12:53 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 + col. 7)	
	6.00	7.00	8.00	9.00	10.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0	113,644,660	0.000000	0.000000	0 50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	2,140,267	0.000000	0.000000	0 52.00
53.00 05300 ANESTHESIOLOGY	0	4,762,962	0.000000	0.000000	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	83,806,212	0.000000	0.000000	34,961 54.00
54.01 05401 FSED RADIOLOGY - DIAGNOSTIC	0	17,034,520	0.000000	0.000000	0 54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	11,557,647	0.000000	0.000000	0 55.00
55.01 05501 WOODLAND CANCER CARE CENTER	0	2,860,374	0.000000	0.000000	0 55.01
57.00 05700 CT SCAN	0	0	0.000000	0.000000	0 57.00
58.00 05800 MRI	0	0	0.000000	0.000000	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0	19,090,555	0.000000	0.000000	0 59.00
60.00 06000 LABORATORY	0	53,073,022	0.000000	0.000000	114,897 60.00
60.01 06001 FSED LABORATORY	0	6,704,085	0.000000	0.000000	0 60.01
65.00 06500 RESPIRATORY THERAPY	0	13,240,068	0.000000	0.000000	21,896 65.00
66.00 06600 PHYSICAL THERAPY	0	18,346,226	0.000000	0.000000	7,702 66.00
69.00 06900 ELECTROCARDIOLOGY	0	15,078,174	0.000000	0.000000	4,384 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	19,929,286	0.000000	0.000000	12,127 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	13,287,219	0.000000	0.000000	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	110,804,654	0.000000	0.000000	260,715 73.00
76.00 03950 CV RESOURCE CENTER	0	0	0.000000	0.000000	0 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000 CLINIC	0	0	0.000000	0.000000	0 90.00
90.01 09001 OB CLINIC	0	0	0.000000	0.000000	0 90.01
90.02 09002 PAIN MANAGEMENT	0	0	0.000000	0.000000	0 90.02
90.03 09003 INFUSION OP SERVICES	0	1,451,837	0.000000	0.000000	0 90.03
90.04 09004 MATERNAL HEA	0	0	0.000000	0.000000	0 90.04
91.00 09100 EMERGENCY	0	48,907,225	0.000000	0.000000	112,274 91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	0	9,407,529	0.000000	0.000000	0 91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	4,345,727	0.000000	0.000000	0 92.00
200.00 Total (lines 50-199)	0	569,472,249			568,956 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0015 Component CCN: 15-S015	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 3/31/2017 12:53 pm
Title XVIII		Subprovider - IPF	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	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	0	0	0	55.01
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 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
60.01	06001 FSED LABORATORY	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03950 CV RESOURCE CENTER	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 OB CLINIC	0	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0	0	0	90.02
90.03	09003 INFUSION OP SERVICES	0	0	0	90.03
90.04	09004 MATERNAL HEA	0	0	0	90.04
91.00	09100 EMERGENCY	0	0	0	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0	0	0	91.01
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 INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-0015 Component CCN: 15-T015	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Prepared: 3/31/2017 12:53 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	2,197,898	113,644,660	0.019340	103,010	1,992	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	204,597	2,140,267	0.095594	0	0	52.00
53.00	05300 ANESTHESIOLOGY	25,569	4,762,962	0.005368	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,444,378	83,806,212	0.017235	172,555	2,974	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	670,698	17,034,520	0.039373	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	353,111	11,557,647	0.030552	3,036	93	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	1,490,653	2,860,374	0.521139	0	0	55.01
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MRI	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	588,849	19,090,555	0.030845	0	0	59.00
60.00	06000 LABORATORY	307,388	53,073,022	0.005792	395,653	2,292	60.00
60.01	06001 FSED LABORATORY	54,845	6,704,085	0.008181	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	101,754	13,240,068	0.007685	325,879	2,504	65.00
66.00	06600 PHYSICAL THERAPY	98,553	18,346,226	0.005372	2,924,535	15,711	66.00
69.00	06900 ELECTROCARDIOLOGY	263,623	15,078,174	0.017484	51,419	899	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	302,687	19,929,286	0.015188	130,019	1,975	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	147,629	13,287,219	0.011111	4,477	50	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	311,733	110,804,654	0.002813	897,941	2,526	73.00
76.00	03950 CV RESOURCE CENTER	436	0	0.000000	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.01	09001 OB CLINIC	0	0	0.000000	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0	0	0.000000	0	0	90.02
90.03	09003 INFUSION OP SERVICES	63,947	1,451,837	0.044046	0	0	90.03
90.04	09004 MATERNAL HEA	0	0	0.000000	0	0	90.04
91.00	09100 EMERGENCY	771,364	48,907,225	0.015772	0	0	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	962,664	9,407,529	0.102329	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	4,345,727	0.000000	3,170	0	92.00
200.00	Total (lines 50-199)	10,362,376	569,472,249		5,011,694	31,016	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0015 Component CCN: 15-T015	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 3/31/2017 12:53 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	0	0	0	0	0 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0 55.00
55.01	05501	WOODLAND CANCER CARE CENTER	0	0	0	0	0 55.01
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	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
60.01	06001	FSED LABORATORY	0	0	0	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03950	CV RESOURCE CENTER	0	0	0	0	0 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.01	09001	OB CLINIC	0	0	0	0	0 90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0 90.02
90.03	09003	INFUSION OP SERVICES	0	0	0	0	0 90.03
90.04	09004	MATERNAL HEA	0	0	0	0	0 90.04
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	0	0	0	0	0 91.01
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: 15-0015 Component CCN: 15-T015	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 3/31/2017 12:53 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 + col. 7)	
	6.00	7.00	8.00	9.00	10.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0	113,644,660	0.000000	0.000000	103,010 50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	2,140,267	0.000000	0.000000	0 52.00
53.00 05300 ANESTHESIOLOGY	0	4,762,962	0.000000	0.000000	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	83,806,212	0.000000	0.000000	172,555 54.00
54.01 05401 FSED RADIOLOGY - DIAGNOSTIC	0	17,034,520	0.000000	0.000000	0 54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	11,557,647	0.000000	0.000000	3,036 55.00
55.01 05501 WOODLAND CANCER CARE CENTER	0	2,860,374	0.000000	0.000000	0 55.01
57.00 05700 CT SCAN	0	0	0.000000	0.000000	0 57.00
58.00 05800 MRI	0	0	0.000000	0.000000	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0	19,090,555	0.000000	0.000000	0 59.00
60.00 06000 LABORATORY	0	53,073,022	0.000000	0.000000	395,653 60.00
60.01 06001 FSED LABORATORY	0	6,704,085	0.000000	0.000000	0 60.01
65.00 06500 RESPIRATORY THERAPY	0	13,240,068	0.000000	0.000000	325,879 65.00
66.00 06600 PHYSICAL THERAPY	0	18,346,226	0.000000	0.000000	2,924,535 66.00
69.00 06900 ELECTROCARDIOLOGY	0	15,078,174	0.000000	0.000000	51,419 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	19,929,286	0.000000	0.000000	130,019 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	13,287,219	0.000000	0.000000	4,477 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	110,804,654	0.000000	0.000000	897,941 73.00
76.00 03950 CV RESOURCE CENTER	0	0	0.000000	0.000000	0 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000 CLINIC	0	0	0.000000	0.000000	0 90.00
90.01 09001 OB CLINIC	0	0	0.000000	0.000000	0 90.01
90.02 09002 PAIN MANAGEMENT	0	0	0.000000	0.000000	0 90.02
90.03 09003 INFUSION OP SERVICES	0	1,451,837	0.000000	0.000000	0 90.03
90.04 09004 MATERNAL HEA	0	0	0.000000	0.000000	0 90.04
91.00 09100 EMERGENCY	0	48,907,225	0.000000	0.000000	0 91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	0	9,407,529	0.000000	0.000000	0 91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	4,345,727	0.000000	0.000000	3,170 92.00
200.00 Total (lines 50-199)	0	569,472,249			5,011,694 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0015 Component CCN: 15-T015	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 3/31/2017 12:53 pm
Title XVIII		Subprovider - IRF	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	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	0	0	0	55.01
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 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
60.01	06001 FSED LABORATORY	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03950 CV RESOURCE CENTER	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 OB CLINIC	0	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0	0	0	90.02
90.03	09003 INFUSION OP SERVICES	0	0	0	90.03
90.04	09004 MATERNAL HEA	0	0	0	90.04
91.00	09100 EMERGENCY	0	0	0	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0	0	0	91.01
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: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 3/31/2017 12:53 pm
		Title XIX	Hospital	Cost

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	0.104949	14,999,699	0	0	1,574,203
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.974527	119,916	0	0	116,861
53.00 05300 ANESTHESIOLOGY	0.041611	649,168	0	0	27,013
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.099826	17,640,393	0	0	1,760,970
54.01 05401 FSED RADIOLOGY - DIAGNOSTIC	0.101136	2,874,747	0	0	290,740
55.00 05500 RADIOLOGY-THERAPEUTIC	0.282277	1,647,939	0	0	465,175
55.01 05501 WOODLAND CANCER CARE CENTER	1.338062	334,271	0	0	447,275
57.00 05700 CT SCAN	0.000000	0	0	0	0
58.00 05800 MRI	0.000000	0	0	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.146856	1,068,739	0	0	156,951
60.00 06000 LABORATORY	0.146324	10,270,915	0	0	1,502,881
60.01 06001 FSED LABORATORY	0.320874	1,159,419	0	0	372,027
65.00 06500 RESPIRATORY THERAPY	0.139899	336,139	0	0	47,026
66.00 06600 PHYSICAL THERAPY	0.227982	2,537,434	0	0	578,489
69.00 06900 ELECTROCARDIOLOGY	0.146346	1,916,868	0	0	280,526
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.557909	1,026,836	0	0	572,881
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.451954	802,587	0	0	362,732
73.00 07300 DRUGS CHARGED TO PATIENTS	0.169920	12,784,038	0	0	2,172,264
76.00 03950 CV RESOURCE CENTER	0.000000	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000 CLINIC	0.000000	0	0	0	0
90.01 09001 OB CLINIC	0.000000	0	0	0	0
90.02 09002 PAIN MANAGEMENT	0.000000	0	0	0	0
90.03 09003 INFUSION OP SERVICES	1.539324	9,271	0	0	14,271
90.04 09004 MATERNAL HEA	0.000000	0	0	0	0
91.00 09100 EMERGENCY	0.198429	14,380,656	0	0	2,853,539
91.01 09101 FREE STANDING EMERGENCY DEPT	0.526672	1,587,436	0	0	836,058
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.802174	1,060,218	0	0	850,479
200.00 Subtotal (see instructions)		87,206,689	0	0	15,282,361
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	
202.00 Net Charges (line 200 +/- line 201)		87,206,689	0	0	15,282,361

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 3/31/2017 12:53 pm
	Title XIX	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	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
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 05401 FSED RADIOLOGY - DIAGNOSTIC	0	0		54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01 05501 WOODLAND CANCER CARE CENTER	0	0		55.01
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 FSED LABORATORY	0	0		60.01
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00 03950 CV RESOURCE CENTER	0	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 OB CLINIC	0	0		90.01
90.02 09002 PAIN MANAGEMENT	0	0		90.02
90.03 09003 INFUSION OP SERVICES	0	0		90.03
90.04 09004 MATERNAL HEA	0	0		90.04
91.00 09100 EMERGENCY	0	0		91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	0	0		91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	0		202.00



COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 3/31/2017 12:53 pm
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)		20,341	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		20,341	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)		17,260	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)		10,053	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)		23,015,122	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)		23,015,122	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)		23,015,122	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)		1,131.46	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		11,374,567	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)		11,374,567	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0015		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 3/31/2017 12: 53 pm	
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)	
NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	4,920,434	2,995	1,642.88	1,456	2,392,033	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							
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					15,682,841	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					29,449,441	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)					1,252,352	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,053,193	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,305,545	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					27,143,896	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)					3,081	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,131.46	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,486,028	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0015		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 3/31/2017 12:53 pm	
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	2,126,085	23,015,122	0.092378	3,486,028	322,032	90.00
91.00	Nursing School cost	0	23,015,122	0.000000	3,486,028	0	91.00
92.00	Allied health cost	0	23,015,122	0.000000	3,486,028	0	92.00
93.00	All other Medical Education	0	23,015,122	0.000000	3,486,028	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0015 Component CCN: 15-S015	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 3/31/2017 12:53 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				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)		3,164	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,164	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,164	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)		986	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)		3,082,091	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)		3,082,091	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)		3,082,091	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)		974.11	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		960,472	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)		960,472	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1		
				Component CCN: 15-S015	Date/Time Prepared: 3/31/2017 12:53 pm			
				Title XVIII	Subprovider - IPF	PPS		
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)			
	1.00	2.00	3.00	4.00	5.00			
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00	
<b>Intensive Care Type Inpatient Hospital Units</b>								
43.00 INTENSIVE CARE UNIT	0	0	0.00	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	
<b>Cost Center Description</b>								
					1.00			
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						99,152		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						1,059,624		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>								
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						69,345		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						4,242		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						73,587		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						986,037		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>								
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>								
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>								
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>								
87.00 Total observation bed days (see instructions)						0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0015 Component CCN: 15-S015		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 3/31/2017 12:53 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	222,533	3,082,091	0.072202	0	0	90.00
91.00	Nursing School cost	0	3,082,091	0.000000	0	0	91.00
92.00	Allied health cost	0	3,082,091	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,082,091	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0015 Component CCN: 15-T015	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 3/31/2017 12:53 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				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)			3,118 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,118 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			3,118 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)			2,361 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)			3,730,442 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)			3,730,442 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)			3,730,442 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)			1,196.42 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,824,748 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)			2,824,748 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1	
				Component CCN: 15-T015	Date/Time Prepared: 3/31/2017 12:53 pm		
				Title XVIII	Subprovider - IRF	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	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
<b>Cost Center Description</b>							
						1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						1,039,896	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						3,864,644	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						281,691	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						31,016	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						312,707	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						3,551,937	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00



COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0015 Component CCN: 15-T015		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 3/31/2017 12:53 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	372,002	3,730,442	0.099721	0	0	90.00
91.00	Nursing School cost	0	3,730,442	0.000000	0	0	91.00
92.00	Allied health cost	0	3,730,442	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,730,442	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 3/31/2017 12:53 pm	
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		16,380,993		30.00
31.00	03100 INTENSIVE CARE UNIT		3,244,879		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.105771	12,971,877	1,372,048	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.974527	5,333	5,197	52.00
53.00	05300 ANESTHESIOLOGY	0.042091	830,046	34,937	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.099826	10,824,721	1,080,589	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0.101136	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.282277	888,368	250,766	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	1.338062	0	0	55.01
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.147199	4,151,529	611,101	59.00
60.00	06000 LABORATORY	0.146629	10,642,415	1,560,487	60.00
60.01	06001 FSED LABORATORY	0.320874	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.139899	6,891,649	964,135	65.00
66.00	06600 PHYSICAL THERAPY	0.229133	1,609,589	368,810	66.00
69.00	06900 ELECTROCARDIOLOGY	0.146346	3,104,758	454,369	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.557909	4,206,133	2,346,639	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.451954	4,703,628	2,125,823	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.169920	18,799,977	3,194,492	73.00
76.00	03950 CV RESOURCE CENTER	0.000000	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 OB CLINIC	0.000000	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0.000000	0	0	90.02
90.03	09003 INFUSION OP SERVICES	1.539324	18,471	28,433	90.03
90.04	09004 MATERNAL HEA	0.000000	0	0	90.04
91.00	09100 EMERGENCY	0.198429	4,101,009	813,759	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0.526672	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.802174	587,473	471,256	92.00
200.00	Total (sum of lines 50-94 and 96-98)		84,336,976	15,682,841	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)		84,336,976		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0015 Component CCN: 15-S015	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 3/31/2017 12:53 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		1,321,692	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.105771	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.974527	0	52.00
53.00	05300	ANESTHESIOLOGY	0.042091	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.099826	34,961	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	0.101136	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.282277	0	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	1.338062	0	55.01
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MRI	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.147199	0	59.00
60.00	06000	LABORATORY	0.146629	114,897	60.00
60.01	06001	FSED LABORATORY	0.320874	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.139899	21,896	65.00
66.00	06600	PHYSICAL THERAPY	0.229133	7,702	66.00
69.00	06900	ELECTROCARDIOLOGY	0.146346	4,384	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.557909	12,127	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.451954	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.169920	260,715	73.00
76.00	03950	CV RESOURCE CENTER	0.000000	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	OB CLINIC	0.000000	0	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	90.02
90.03	09003	INFUSION OP SERVICES	1.539324	0	90.03
90.04	09004	MATERNAL HEA	0.000000	0	90.04
91.00	09100	EMERGENCY	0.198429	112,274	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	0.526672	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.802174	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		568,956	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)		568,956	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0015 Component CCN: 15-T015	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 3/31/2017 12:53 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		2,945,207		41.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.105771	103,010	10,895	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.974527	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.042091	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.099826	172,555	17,225	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0.101136	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.282277	3,036	857	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	1.338062	0	0	55.01
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.147199	0	0	59.00
60.00	06000 LABORATORY	0.146629	395,653	58,014	60.00
60.01	06001 FSED LABORATORY	0.320874	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.139899	325,879	45,590	65.00
66.00	06600 PHYSICAL THERAPY	0.229133	2,924,535	670,107	66.00
69.00	06900 ELECTROCARDIOLOGY	0.146346	51,419	7,525	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.557909	130,019	72,539	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.451954	4,477	2,023	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.169920	897,941	152,578	73.00
76.00	03950 CV RESOURCE CENTER	0.000000	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 OB CLINIC	0.000000	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0.000000	0	0	90.02
90.03	09003 INFUSION OP SERVICES	1.539324	0	0	90.03
90.04	09004 MATERNAL HEA	0.000000	0	0	90.04
91.00	09100 EMERGENCY	0.198429	0	0	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0.526672	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.802174	3,170	2,543	92.00
200.00	Total (sum of lines 50-94 and 96-98)		5,011,694	1,039,896	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		5,011,694		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 3/31/2017 12:53 pm	
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		5,739,412		30.00
31.00	03100 INTENSIVE CARE UNIT		1,309,733		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.104949	5,538,936	581,306	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.974527	1,229,918	1,198,588	52.00
53.00	05300 ANESTHESIOLOGY	0.041611	346,632	14,424	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.099826	2,724,804	272,006	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0.101136	122,798	12,419	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.282277	332,318	93,806	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	1.338062	262	351	55.01
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.146856	1,252,209	183,894	59.00
60.00	06000 LABORATORY	0.146324	3,932,430	575,409	60.00
60.01	06001 FSED LABORATORY	0.320874	11,845	3,801	60.01
65.00	06500 RESPIRATORY THERAPY	0.139899	1,896,874	265,371	65.00
66.00	06600 PHYSICAL THERAPY	0.227982	249,408	56,861	66.00
69.00	06900 ELECTROCARDIOLOGY	0.146346	810,466	118,608	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.557909	1,327,353	740,542	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.451954	1,249,081	564,527	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.169920	7,637,509	1,297,766	73.00
76.00	03950 CV RESOURCE CENTER	0.000000	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 OB CLINIC	0.000000	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0.000000	0	0	90.02
90.03	09003 INFUSION OP SERVICES	1.539324	0	0	90.03
90.04	09004 MATERNAL HEA	0.000000	0	0	90.04
91.00	09100 EMERGENCY	0.198429	1,260,278	250,076	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0.526672	99,425	52,364	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.802174	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		30,022,546	6,282,119	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)		30,022,546		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0015 Component CCN: 15-S015	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 3/31/2017 12:53 pm
		Title XIX	Subprovider - IPF	Cost
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		1,878,240	40.00
41.00	04100 SUBPROVIDER - IRF		0	41.00
43.00	04300 NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.104949	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.974527	0	52.00
53.00	05300 ANESTHESIOLOGY	0.041611	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.099826	0	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0.101136	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.282277	0	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	1.338062	0	55.01
57.00	05700 CT SCAN	0.000000	0	57.00
58.00	05800 MRI	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.146856	0	59.00
60.00	06000 LABORATORY	0.146324	0	60.00
60.01	06001 FSED LABORATORY	0.320874	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.139899	0	65.00
66.00	06600 PHYSICAL THERAPY	0.227982	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.146346	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.557909	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.451954	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.169920	0	73.00
76.00	03950 CV RESOURCE CENTER	0.000000	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000	0	90.00
90.01	09001 OB CLINIC	0.000000	0	90.01
90.02	09002 PAIN MANAGEMENT	0.000000	0	90.02
90.03	09003 INFUSION OP SERVICES	1.539324	0	90.03
90.04	09004 MATERNAL HEA	0.000000	0	90.04
91.00	09100 EMERGENCY	0.198429	0	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0.526672	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.802174	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		0	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)		0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0015 Component CCN: 15-T015	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 3/31/2017 12:53 pm
		Title XIX	Subprovider - IRF	Cost
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		0	40.00
41.00	04100 SUBPROVIDER - IRF		484,788	41.00
43.00	04300 NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.104949	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.974527	0	52.00
53.00	05300 ANESTHESIOLOGY	0.041611	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.099826	0	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0.101136	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.282277	0	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	1.338062	0	55.01
57.00	05700 CT SCAN	0.000000	0	57.00
58.00	05800 MRI	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.146856	0	59.00
60.00	06000 LABORATORY	0.146324	0	60.00
60.01	06001 FSED LABORATORY	0.320874	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.139899	0	65.00
66.00	06600 PHYSICAL THERAPY	0.227982	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.146346	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.557909	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.451954	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.169920	0	73.00
76.00	03950 CV RESOURCE CENTER	0.000000	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000	0	90.00
90.01	09001 OB CLINIC	0.000000	0	90.01
90.02	09002 PAIN MANAGEMENT	0.000000	0	90.02
90.03	09003 INFUSION OP SERVICES	1.539324	0	90.03
90.04	09004 MATERNAL HEA	0.000000	0	90.04
91.00	09100 EMERGENCY	0.198429	0	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0.526672	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.802174	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		0	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)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 3/31/2017 12: 53 pm
		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)		16,349,881	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		6,118,644	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)		576,500	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		140.58	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).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
<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)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment ( sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.44	30.00
31.00	Percentage of Medicaid patient days (see instructions)		22.85	31.00
32.00	Sum of lines 30 and 31		26.29	32.00
33.00	Allowable disproportionate share percentage (see instructions)		10.90	33.00
34.00	Disproportionate share adjustment (see instructions)		612,267	34.00



CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 3/31/2017 12:53 pm
		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)	0.000151187	0.000148174	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	968,526	885,709	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	725,071	223,247	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	948,318		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)	24,605,610		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>
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		24,605,610	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,983,442	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		1,036	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)		26,590,088	59.00
60.00	Primary payer payments		3,295	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		26,586,793	61.00
62.00	Deductibles billed to program beneficiaries		2,459,520	62.00
63.00	Coinurance billed to program beneficiaries		100,142	63.00
64.00	Allowable bad debts (see instructions)		394,178	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		256,216	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		82,393	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		24,283,347	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)		-68,874	70.93
70.94	HRR adjustment amount (see instructions)		-97,473	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 3/31/2017 12:53 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
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	1.00	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)			24,117,000	71.00
71.01	Sequestration adjustment (see instructions)			482,340	71.01
72.00	Interim payments			23,504,380	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)			130,280	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			1,350,660	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)		1.0000500000	0.9984300000	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)		0.9946	0.9985	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0015

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
3/31/2017 12:53 pm

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	16,349,881	0	16,349,881		16,349,881	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,118,644	0		6,118,644	6,118,644	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	576,500	0	402,786	173,714	576,500	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
<b>Indirect Medical Education Adjustment</b>								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1090	0.1090	0.1090	0.1090		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	612,267	0	445,534	166,733	612,267	11.00
11.01	Uncompensated care payments	36.00	948,318	0	948,318	0	948,318	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	24,605,610	0	18,146,519	6,459,091	24,605,610	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	24,605,610	0	18,146,519	6,459,091	24,605,610	15.00
16.00	Payment for inpatient program capital	50.00	1,983,442	0	1,444,200	539,242	1,983,442	16.00
17.00	Special add-on payments for new technologies	54.00	1,036	0	1,036	0	1,036	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0015

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
3/31/2017 12: 53 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	19,591,755	6,998,333	26,590,088	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,800,407	0	1,306,326	494,081	1,800,407	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	84,733	0	66,549	18,184	84,733	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0546	0.0546	0.0546	0.0546		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	98,302	0	71,325	26,977	98,302	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,983,442	0	1,444,200	539,242	1,983,442	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0015		Period: From 01/01/2016 To 12/31/2016		Worksheet E Part A Exhibit 5 Date/Time Prepared: 3/31/2017 12:53 pm	
Title XVIII				Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	16,349,881	16,349,881		16,349,881	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,118,644		6,118,644	6,118,644	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	576,500	402,786	173,714	576,500	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	2,229,414	918,540	3,147,954	4.00
<b>Indirect Medical Education Adjustment</b>							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
<b>Disproportionate Share Adjustment</b>							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1090	0.1090	0.1090		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	612,267	445,534	166,733	612,267	11.00
11.01	Uncompensated care payments	36.00	948,318	667,548	228,855	896,403	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	24,605,610	17,917,664	6,687,946	24,605,610	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	24,605,610	17,917,664	6,687,946	24,605,610	15.00
16.00	Payment for inpatient program capital	50.00	1,983,442	1,444,200	539,242	1,983,442	16.00
17.00	Special add-on payments for new technologies	54.00	1,036	1,036	0	1,036	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	<b>SUBTOTAL</b>			19,362,900	7,227,188	26,590,088	19.00

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,800,407	1,306,326	494,081	1,800,407	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	84,733	66,549	18,184	84,733	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0546	0.0546	0.0546		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	98,302	71,325	26,977	98,302	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,983,442	1,444,200	539,242	1,983,442	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-68,874	-22,301	-46,573	-68,874	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-97,473	-88,294	-9,179	-97,473	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 3/31/2017 12:53 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		4,026	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		22,725,379	2.00
3.00	PPS payments		17,678,941	3.00
4.00	Outlier payment (see instructions)		20,530	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)		4,026	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		23,740	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)		23,740	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)		23,740	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		19,714	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)		4,026	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)		17,699,471	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		3,543,400	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)		14,160,097	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		14,160,097	30.00
31.00	Primary payer payments		6,512	31.00
32.00	Subtotal (line 30 minus line 31)		14,153,585	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)		751,398	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		488,409	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		427,085	36.00
37.00	Subtotal (see instructions)		14,641,994	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		14,641,994	40.00
40.01	Sequestration adjustment (see instructions)		292,840	40.01
41.00	Interim payments		14,372,877	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-23,723	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: 15-0015

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
3/31/2017 12:53 pm

		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		23,454,880		14,283,477	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	03/19/2016	49,500	03/19/2016	89,400	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)		49,500		89,400	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)		23,504,380		14,372,877	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		130,280		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		23,723	6.02	
7.00	Total Medicare program liability (see instructions)		23,634,660		14,349,154	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	



ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0015  
Component CCN: 15-S015

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
3/31/2017 12:53 pm

Title XVIII

Subprovider -  
IPF

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		631,232		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		631,232		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		12,613		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		643,845		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0015  
Component CCN: 15-T015

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
3/31/2017 12:53 pm

Title XVIII

Subprovider -  
IRF

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					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		3,115,980		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,115,980		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		24,278		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,140,258		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 15-0015

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

Worksheet E-1  
Part II  
Date/Time Prepared:  
3/31/2017 12:53 pm

		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			5,407 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			11,509 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			1,673 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			20,255 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			622,128,778 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			30,672,374 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)			488,051 8.00
9.00	Sequestration adjustment amount (see instructions)			9,761 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			478,290 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)			478,290 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0015 Component CCN: 15-S015	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part II Date/Time Prepared: 3/31/2017 12:53 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			769,216 1.00
2.00	Net IPF PPS Outlier Payments			28,417 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			8.644809 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$ .			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			797,633 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			797,633 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			797,633 18.00
19.00	Deductibles			61,740 19.00
20.00	Subtotal (line 18 minus line 19)			735,893 20.00
21.00	Coinsurance			91,770 21.00
22.00	Subtotal (line 20 minus line 21)			644,123 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			19,788 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			12,862 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,585 25.00
26.00	Subtotal (sum of lines 22 and 24)			656,985 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			656,985 31.00
31.01	Sequestration adjustment (see instructions)			13,140 31.01
32.00	Interim payments			631,232 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			12,613 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			28,417 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0015 Component CCN: 15-T015	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part III Date/Time Prepared: 3/31/2017 12:53 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)			2,980,181 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0101 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			65,564 3.00
4.00	Outlier Payments			178,709 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			8.519126 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			3,224,454 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			3,224,454 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			3,224,454 19.00
20.00	Deductibles			11,592 20.00
21.00	Subtotal (line 19 minus line 20)			3,212,862 21.00
22.00	Coinsurance			14,168 22.00
23.00	Subtotal (line 21 minus line 22)			3,198,694 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			8,694 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			5,651 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			8,694 26.00
27.00	Subtotal (sum of lines 23 and 25)			3,204,345 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			3,204,345 32.00
32.01	Sequestration adjustment (see instructions)			64,087 32.01
33.00	Interim payments			3,115,980 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)			24,278 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			178,709 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 3/31/2017 12:53 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		30,022,546	87,206,689	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		30,022,546	87,206,689	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		30,022,546	87,206,689	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		30,022,546	87,206,689	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0015 Component CCN: 15-S015	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 3/31/2017 12:53 pm	
		Title XIX	Subprovider - IPF	Cost	
			Inpatient 1.00	Outpatient 2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services		0	0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0		41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0015 Component CCN: 15-T015	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 3/31/2017 12:53 pm	
		Title XIX	Subprovider - IRF	Cost	
			Inpatient 1.00	Outpatient 2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00



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

Provider CCN: 15-0015

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

Worksheet G  
Date/Time Prepared:  
3/31/2017 12:53 pm

		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	104,855,165	0	0	0	1.00
2.00	Temporary investments	8,174,984	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	30,143,088	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,502,250	0	0	0	6.00
7.00	Inventory	3,677,410	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	2,549,804	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)	140,898,201	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	7,180,112	0	0	0	12.00
13.00	Land improvements	4,044,463	0	0	0	13.00
14.00	Accumulated depreciation	-2,374,593	0	0	0	14.00
15.00	Buildings	92,808,827	0	0	0	15.00
16.00	Accumulated depreciation	-50,891,156	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	144,877,054	0	0	0	23.00
24.00	Accumulated depreciation	-68,183,611	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)	127,461,096	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	111,978	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	2,684,884	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,796,862	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	271,156,159	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	11,279,302	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,506,744	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	1,022,558	0	0	0	43.00
44.00	Other current liabilities	5,025,649	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	21,834,253	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	148,376	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	359,758	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	508,134	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	22,342,387	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	248,813,772				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	248,813,772	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	271,156,159	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0015

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

Worksheet G-1

Date/Time Prepared:  
3/31/2017 12:53 pm

		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		199,226,055		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		51,602,607			2.00
3.00	Total (sum of line 1 and line 2)		250,828,662		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		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)		250,828,662		0	11.00
12.00	FUND BALANCE ADJUSTMENT	2,014,880		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		2,014,880		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		248,813,782		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	FUND BALANCE ADJUSTMENT		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: 15-0015

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
3/31/2017 12:53 pm

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	34,261,661		34,261,661	1.00
2.00	SUBPROVIDER - IPF	7,657,275		7,657,275	2.00
3.00	SUBPROVIDER - IRF	4,242,765		4,242,765	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	46,161,701		46,161,701	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	6,494,828		6,494,828	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)	6,494,828		6,494,828	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	52,656,529		52,656,529	17.00
18.00	Ancillary services	151,881,853	353,478,078	505,359,931	18.00
19.00	Outpatient services	11,612,357	52,499,961	64,112,318	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	OTHER REVENUE	0	3,053,495	3,053,495	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	216,150,739	409,031,534	625,182,273	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		168,182,921		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)		168,182,921		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0015

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

Worksheet G-3

Date/Time Prepared:  
3/31/2017 12:53 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	625,182,273	1.00
2.00	Less contractual allowances and discounts on patients' accounts	450,135,206	2.00
3.00	Net patient revenues (line 1 minus line 2)	175,047,067	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	168,182,921	4.00
5.00	Net income from service to patients (line 3 minus line 4)	6,864,146	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	29,674	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	724,962	10.00
11.00	Rebates and refunds of expenses	5,243	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	623,253	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	9,292	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	16,788	21.00
22.00	Rental of hospital space	329,615	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REV & PREMIUM REV	10,990,869	24.00
25.00	Total other income (sum of lines 6-24)	12,729,696	25.00
26.00	Total (line 5 plus line 25)	19,593,842	26.00
27.00	BD DEBT, EQUITY XFR, MINORITY INT	-32,008,765	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-32,008,765	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	51,602,607	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0015	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 3/31/2017 12:53 pm
		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		1,800,407	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		84,733	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)		58.60	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		3.44	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		22.85	8.00
9.00	Sum of lines 7 and 8		26.29	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.46	10.00
11.00	Disproportionate share adjustment (see instructions)		98,302	11.00
12.00	Total prospective capital payments (see instructions)		1,983,442	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