

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: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/30/2017 11:30 am
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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: 5/30/2017 Time: 11:30 am

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 HENDRICKS REGIONAL HEALTH (15-0005) 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			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	10,149	-118,295	0	152,677	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	10,149	-118,295	0	152,677	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0005		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 11:29 am				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1000 EAST MAIN STREET	PO Box:							1.00	
2.00	City: DANVILLE	State: IN		Zip Code: 46122-1409		County: HENDRICKS			2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	HENDRICKS REGIONAL HEALTH	150005	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2016	12/31/2016		20.00	
21.00	Type of Control (see instructions)					2			21.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3		N	23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	588	685	0	0	2,460	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 11:29 am		
		Urban/Rural S 1.00	Date of Geogr 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: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 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 1.00	XVII 2.00	XIX 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 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 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)				0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05

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	Y/N	IME	Direct GME	IME	Direct GME			
	1.00	2.00	3.00	4.00	5.00			
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06	
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00	2.00	3.00	4.00				
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.						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.						61.20	
						1.00		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)								
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						62.00	0.00
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)						62.01	0.00
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)						63.00	N
			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)						64.00	0.000000
		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)						65.00	0.000000

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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
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	0	76.00
					1.00	
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			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	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	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			
Rural Providers									
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N				105.00			
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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		Occupational		Speech		Respiratory	
		1.00		2.00		3.00		4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N		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	
								1.00	
								2.00	
								3.00	
Miscellaneous Cost Reporting Information									
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0		115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N						116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y						117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1						118.00	
		Premiums		Losses		Insurance			
		1.00		2.00		3.00			
118.01	List amounts of malpractice premiums and paid losses:	888,708		0		0		118.01	
								1.00	
								2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N						118.02	
119.00	DO NOT USE THIS LINE							119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N				120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y						121.00	
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y		5.00				122.00	
Transplant Center Information									
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N						125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 11:29 am		
		1.00	2.00			
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				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:	Contractor's Name:		Contractor's Number:		141.00
142.00	Street:	PO Box:				142.00
143.00	City:	State:		Zip Code:		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.	Y				145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00
						1.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00
		Part A	Part B	Title V	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
Multi campus						
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00
		Name	County	State	Zip Code	CBSA
		0	1.00	2.00	3.00	4.00
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.			N		167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			0		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00		169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/30/2017 11:29 am
			Beginning	Ending
			1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			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: 15-0005		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 11:29 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					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)	Y	05/09/2017	Y	05/09/2017		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)	N		N			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: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 11:29 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
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
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N		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	
Home Office Costs					
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		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MICHAEL		ALESSANDRINI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.713.7959		MALESSANDRINI@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/30/2017 11:29 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DI RECTOR		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: 15-0005

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2017 11:29 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					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	115	42,090	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)		115	42,090	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,392	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY					0	13.00
14.00 Total (see instructions)		127	46,482	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		127				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: 15-0005

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2017 11:29 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,382	569	16,013			1.00
2.00 HMO and other (see instructions)	2,525	2,968				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	6,382	569	16,013			7.00
8.00 INTENSIVE CARE UNIT	855	0	1,856			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		0	3,129			13.00
14.00 Total (see instructions)	7,237	569	20,998	0.00	1,325.30	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	1,325.30	27.00
28.00 Observation Bed Days		0	3,436			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	196	462			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: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part I Date/Time Prepared: 5/30/2017 11:29 am
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Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	1,994	114	5,608	1.00
2.00	HMO and other (see instructions)			659	737		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	1,994	114	5,608	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part II Date/Time Prepared: 5/30/2017 11:29 am			
	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	102,226,120	0	102,226,120	2,714,087.00	37.67	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		15,683	0	15,683	111.00	141.29	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non-Physician-Part B		7,758,463	0	7,758,463	54,716.00	141.80	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		31,599,244	0	31,599,244	642,060.00	49.22	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract Labor: Direct Patient Care		1,946,873	0	1,946,873	17,806.00	109.34	11.00
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		948,114	0	948,114	7,343.00	129.12	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		20,731,282	0	20,731,282			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		6,994,372	0	6,994,372			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		2,085	0	2,085			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		974,434	0	974,434			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		0	0	0			25.50
25.51	Related organization wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0005

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

Worksheet S-3
Part II
Date/Time Prepared:
5/30/2017 11:29 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion 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	
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	1,245,317	0	1,245,317	36,987.00	33.67 26.00
27.00	Administrative & General	5.00	11,170,498	0	11,170,498	256,019.00	43.63 27.00
28.00	Administrative & General under contract (see inst.)		4,747,785	0	4,747,785	17,948.00	264.53 28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00 29.00
30.00	Operation of Plant	7.00	2,481,870	0	2,481,870	94,483.00	26.27 30.00
31.00	Laundry & Linen Service	8.00	325,676	0	325,676	21,205.00	15.36 31.00
32.00	Housekeeping	9.00	1,953,789	0	1,953,789	125,041.00	15.63 32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00 33.00
34.00	Dietary	10.00	1,557,124	-1,093,870	463,254	26,110.00	17.74 34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00 35.00
36.00	Cafeteria	11.00	0	1,093,870	1,093,870	61,654.00	17.74 36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00 37.00
38.00	Nursing Administration	13.00	1,919,592	0	1,919,592	56,737.00	33.83 38.00
39.00	Central Services and Supply	14.00	757,668	0	757,668	33,659.00	22.51 39.00
40.00	Pharmacy	15.00	1,938,321	0	1,938,321	49,276.00	39.34 40.00
41.00	Medical Records & Medical Records Library	16.00	1,292,912	0	1,292,912	56,805.00	22.76 41.00
42.00	Social Service	17.00	1,697,391	0	1,697,391	49,724.00	34.14 42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00 43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0005

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

Worksheet S-3
Part III
Date/Time Prepared:
5/30/2017 11:29 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	99,215,442	0	99,215,442	2,677,319.00	37.06	1.00
2.00	Excluded area salaries (see instructions)	31,599,244	0	31,599,244	642,060.00	49.22	2.00
3.00	Subtotal salaries (line 1 minus line 2)	67,616,198	0	67,616,198	2,035,259.00	33.22	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,894,987	0	2,894,987	25,149.00	115.11	4.00
5.00	Subtotal wage-related costs (see inst.)	20,733,367	0	20,733,367	0.00	30.66	5.00
6.00	Total (sum of lines 3 thru 5)	91,244,552	0	91,244,552	2,060,408.00	44.28	6.00
7.00	Total overhead cost (see instructions)	31,087,943	0	31,087,943	885,648.00	35.10	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part IV Date/Time Prepared: 5/30/2017 11:29 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		3,737,556	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		1,665,581	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		58,642	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		15,430,280	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		0	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		289,860	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)		2,245	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		727,163	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		6,529,809	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		22,213	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		238,824	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		28,702,173	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part V Date/Time Prepared: 5/30/2017 11:29 am
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			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)		0	0 5.00
6.00	Swing Beds - SNF		0	0 6.00
7.00	Swing Beds - NF		0	0 7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis		0	0 17.00
18.00	Other		0	0 18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet S-10 Date/Time Prepared: 5/30/2017 11:29 am	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.320037	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			11,448,496	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			57,377,886	6.00
7.00	Medicaid cost (line 1 times line 6)			18,363,047	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)			6,914,551	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)			6,914,551	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)	8,726,818	0	8,726,818	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	2,792,905	0	2,792,905	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,792,905	0	2,792,905	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)			23,085,494	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			206,551	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			22,878,943	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			7,322,108	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			10,115,013	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			17,029,564	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 15-0005		Period: From 01/01/2016 To 12/31/2016		Worksheet A	
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	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		23,121,739	23,121,739	0	23,121,739	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,245,317	5,304,725	6,550,042	6,618	6,556,660	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,170,498	30,331,823	41,502,321	50,321	41,552,642	5.00
7.00	00700	OPERATION OF PLANT	2,481,870	7,338,644	9,820,514	11,837	9,832,351	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	325,676	338,620	664,296	35,185	699,481	8.00
9.00	00900	HOUSEKEEPING	1,953,789	1,151,548	3,105,337	0	3,105,337	9.00
10.00	01000	DIETARY	1,557,124	1,702,419	3,259,543	-2,289,888	969,655	10.00
11.00	01100	CAFETERIA	0	0	0	2,289,809	2,289,809	11.00
13.00	01300	NURSING ADMINISTRATION	1,919,592	797,029	2,716,621	-1,540	2,715,081	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	757,668	821,781	1,579,449	-4,475	1,574,974	14.00
15.00	01500	PHARMACY	1,938,321	10,037,034	11,975,355	-8,384,637	3,590,718	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,292,912	1,604,986	2,897,898	2,231	2,900,129	16.00
17.00	01700	SOCIAL SERVICE	1,697,391	596,279	2,293,670	13,729	2,307,399	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,823,979	4,441,429	14,265,408	-375,043	13,890,365	30.00
31.00	03100	INTENSIVE CARE UNIT	1,645,336	696,204	2,341,540	-111,266	2,230,274	31.00
43.00	04300	NURSERY	629,342	190,785	820,127	-69,955	750,172	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,483,368	8,856,322	10,339,690	-2,677,204	7,662,486	50.00
50.01	05001	ENDOSCOPY	968,764	684,393	1,653,157	-277,601	1,375,556	50.01
51.00	05100	RECOVERY ROOM	1,181,195	434,136	1,615,331	-95,993	1,519,338	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,709,270	296,323	2,005,593	-41,910	1,963,683	52.00
53.00	05300	ANESTHESIOLOGY	4,879,621	1,037,847	5,917,468	-197,150	5,720,318	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,183,237	2,408,483	6,591,720	-296,366	6,295,354	54.00
54.01	05401	RADIATION-ONCOLOGY	1,047,020	14,352,180	15,399,200	166,165	15,565,365	54.01
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	143,807	243,951	387,758	-1,692	386,066	56.00
59.00	05900	CARDIAC CATHETERIZATION	558,767	985,364	1,544,131	-754,908	789,223	59.00
60.00	06000	LABORATORY	2,491,499	4,899,108	7,390,607	2,772	7,393,379	60.00
64.00	06400	INTRAVENOUS THERAPY	877,639	291,424	1,169,063	124,930	1,293,993	64.00
65.00	06500	RESPIRATORY THERAPY	1,632,433	849,300	2,481,733	-61,659	2,420,074	65.00
66.00	06600	PHYSICAL THERAPY	4,442,301	1,919,212	6,361,513	-244,785	6,116,728	66.00
67.00	06700	OCCUPATIONAL THERAPY	358,262	113,452	471,714	16,008	487,722	67.00
68.00	06800	SPEECH PATHOLOGY	300,538	95,008	395,546	0	395,546	68.00
69.00	06900	ELECTROCARDIOLOGY	506,456	448,590	955,046	-3,999	951,047	69.00
69.01	06901	CARDIAC REHAB	394,690	136,582	531,272	-4,588	526,684	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	101,147	28,074	129,221	0	129,221	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	6,733,614	6,733,614	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,308,025	11,308,025	73.00
73.01	07301	ULTRA SOUND	429,827	252,564	682,391	-30,709	651,682	73.01
74.00	07400	RENAL DIALYSIS	0	157,149	157,149	-1,044	156,105	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,541,158	4,538,729	6,079,887	-269,759	5,810,128	90.00
91.00	09100	EMERGENCY	2,957,062	2,131,219	5,088,281	-319,247	4,769,034	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	70,626,876	133,634,455	204,261,331	4,245,826	208,507,157	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	25,667,448	16,916,287	42,583,735	-4,028,307	38,555,428	192.00
192.01	19201	HEALTH TRACKS	2,819,924	1,044,368	3,864,292	-58,457	3,805,835	192.01
194.00	07950	PRIMARY CARE CLINIC	863,130	1,005,938	1,869,068	-13,684	1,855,384	194.00
194.01	07951	PARTNERS IN CARE	627,693	298,121	925,814	-62,399	863,415	194.01
194.02	07952	OCCUPATIONAL MEDICINE	233,599	606,686	840,285	-51,387	788,898	194.02
194.03	07953	FOUNDATION	173,600	60,187	233,787	0	233,787	194.03
194.04	07954	SCHOOL & TOWN CLINICS	1,213,850	315,221	1,529,071	-31,592	1,497,479	194.04
200.00		TOTAL (SUM OF LINES 118-199)	102,226,120	153,881,263	256,107,383	0	256,107,383	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0005

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

Worksheet A
Date/Time Prepared:
5/30/2017 11:29 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-975,465	22,146,274	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-69,404	6,487,256	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-8,575,405	32,977,237	5.00
7.00	00700 OPERATION OF PLANT	-568,154	9,264,197	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	699,481	8.00
9.00	00900 HOUSEKEEPING	0	3,105,337	9.00
10.00	01000 DIETARY	-392,858	576,797	10.00
11.00	01100 CAFETERIA	-782,024	1,507,785	11.00
13.00	01300 NURSING ADMINISTRATION	-22,352	2,692,729	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-98	1,574,876	14.00
15.00	01500 PHARMACY	0	3,590,718	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-1,308	2,898,821	16.00
17.00	01700 SOCIAL SERVICE	0	2,307,399	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-2,371,059	11,519,306	30.00
31.00	03100 INTENSIVE CARE UNIT	0	2,230,274	31.00
43.00	04300 NURSERY	0	750,172	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	7,662,486	50.00
50.01	05001 ENDOSCOPY	0	1,375,556	50.01
51.00	05100 RECOVERY ROOM	0	1,519,338	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,963,683	52.00
53.00	05300 ANESTHESIOLOGY	-4,879,437	840,881	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-94,353	6,201,001	54.00
54.01	05401 RADIOLOGY-ONCOLOGY	0	15,565,365	54.01
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	386,066	56.00
59.00	05900 CARDIAC CATHETERIZATION	0	789,223	59.00
60.00	06000 LABORATORY	-31,156	7,362,223	60.00
64.00	06400 INTRAVENOUS THERAPY	0	1,293,993	64.00
65.00	06500 RESPIRATORY THERAPY	0	2,420,074	65.00
66.00	06600 PHYSICAL THERAPY	-556,772	5,559,956	66.00
67.00	06700 OCCUPATIONAL THERAPY	-31,363	456,359	67.00
68.00	06800 SPEECH PATHOLOGY	-12,545	383,001	68.00
69.00	06900 ELECTROCARDIOLOGY	-132,902	818,145	69.00
69.01	06901 CARDIAC REHAB	0	526,684	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	129,221	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	6,733,614	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	11,308,025	73.00
73.01	07301 ULTRA SOUND	0	651,682	73.01
74.00	07400 RENAL DIALYSIS	0	156,105	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	33,513	5,843,641	90.00
91.00	09100 EMERGENCY	-39,484	4,729,550	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-19,502,626	189,004,531	118.00
NONREIMBURSABLE COST CENTERS				
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	38,555,428	192.00
192.01	19201 HEALTH TRACKS	0	3,805,835	192.01
194.00	07950 PRIMARY CARE CLINIC	0	1,855,384	194.00
194.01	07951 PARTNERS IN CARE	0	863,415	194.01
194.02	07952 OCCUPATIONAL MEDICINE	0	788,898	194.02
194.03	07953 FOUNDATION	0	233,787	194.03
194.04	07954 SCHOOL & TOWN CLINICS	0	1,497,479	194.04
200.00	TOTAL (SUM OF LINES 118-199)	-19,502,626	236,604,757	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - DRUG RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,308,025	1.00
2.00	INTRAVENOUS THERAPY	64.00	0	181,924	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
O			0	11,489,949	
B - MOB PLANT RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,751	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	50,362	2.00
3.00	OPERATION OF PLANT	7.00	0	11,837	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	35,591	4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,231	5.00
6.00	SOCIAL SERVICE	17.00	0	13,729	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	76,457	7.00
8.00	RADIATION-ONCOLOGY	54.01	0	121,764	8.00
9.00	LABORATORY	60.00	0	4,330	9.00
10.00	RESPIRATORY THERAPY	65.00	0	2,500	10.00
11.00	PHYSICAL THERAPY	66.00	0	20,142	11.00
12.00	OCCUPATIONAL THERAPY	67.00	0	20,135	12.00
13.00	CLINIC	90.00	0	145,104	13.00
O			0	511,933	
C - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	1,093,870	1,195,939	1.00
O			1,093,870	1,195,939	
D - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	6,733,614	1.00
2.00		0.00	0	0	2.00
O			0	6,733,614	
F - MEDICAL SUPPLY RECLASS					
1.00	OPERATING ROOM	50.00	0	3,700,320	1.00
2.00	RADIATION-ONCOLOGY	54.01	0	44,401	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00

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Period:
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Worksheet A-6
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
	0		0	3,744,721		
500.00	Grand Total: Increases		1,093,870	23,676,156		500.00

RECLASSIFICATIONS

Provider CCN: 15-0005

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

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		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - DRUG RECLASS							
1.00	PHARMACY	15.00	0	8,367,424	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	5,293	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	227	0		3.00
4.00	NURSERY	43.00	0	804	0		4.00
5.00	OPERATING ROOM	50.00	0	9,971	0		5.00
6.00	ENDOSCOPY	50.01	0	39	0		6.00
7.00	RECOVERY ROOM	51.00	0	874	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,281	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,759	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	90	0		10.00
11.00	LABORATORY	60.00	0	81	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	438	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	67,478	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	157	0		14.00
15.00	CARDIAC REHAB	69.01	0	7	0		15.00
16.00	RENAL DIALYSIS	74.00	0	1,044	0		16.00
17.00	CLINIC	90.00	0	4,074	0		17.00
18.00	EMERGENCY	91.00	0	976	0		18.00
19.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,892,914	0		19.00
20.00	HEALTH TRACKS	192.01	0	28,129	0		20.00
21.00	PRIMARY CARE CLINIC	194.00	0	9,715	0		21.00
22.00	PARTNERS IN CARE	194.01	0	21,859	0		22.00
23.00	OCCUPATIONAL MEDICINE	194.02	0	40,814	0		23.00
24.00	SCHOOL & TOWN CLINICS	194.04	0	30,501	0		24.00
O			0	11,489,949			
B - MOB PLANT RECLASS							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	511,933	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
O			0	511,933			
C - CAFETERIA RECLASS							
1.00	DIETARY	10.00	1,093,870	1,195,939	0		1.00
O			1,093,870	1,195,939			
D - IMPLANTABLE DEVICES							
1.00	OPERATING ROOM	50.00	0	6,323,152	0		1.00
2.00	CLINIC	90.00	0	410,462	0		2.00
O			0	6,733,614			
F - MEDICAL SUPPLY RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,133	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	41	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	406	0		3.00
4.00	DIETARY	10.00	0	79	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	1,540	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	4,475	0		6.00
7.00	PHARMACY	15.00	0	17,213	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	369,750	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	111,039	0		9.00
10.00	NURSERY	43.00	0	69,151	0		10.00
11.00	ENDOSCOPY	50.01	0	277,562	0		11.00
12.00	RECOVERY ROOM	51.00	0	95,119	0		12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	40,629	0		13.00
14.00	ANESTHESIOLOGY	53.00	0	197,150	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	367,064	0		15.00
16.00	OPERATING ROOM	50.00	0	44,401	0		16.00
17.00	NUCLEAR MEDICINE - DIAGNOSTIC	56.00	0	1,692	0		17.00
18.00	CARDIAC CATHETERIZATION	59.00	0	754,818	0		18.00
19.00	LABORATORY	60.00	0	1,477	0		19.00
20.00	INTRAVENOUS THERAPY	64.00	0	56,994	0		20.00
21.00	RESPIRATORY THERAPY	65.00	0	63,721	0		21.00
22.00	PHYSICAL THERAPY	66.00	0	197,449	0		22.00
23.00	OCCUPATIONAL THERAPY	67.00	0	4,127	0		23.00
24.00	ELECTROCARDIOLOGY	69.00	0	3,842	0		24.00

Provider CCN: 15-0005

Period:
From 01/01/2016
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Worksheet A-6
Date/Time Prepared:
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		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
25.00	CARDIAC REHAB	69.01	0	4,581	0			25.00
26.00	ULTRA SOUND	73.01	0	30,709	0			26.00
27.00	CLINIC	90.00	0	327	0			27.00
28.00	EMERGENCY	91.00	0	318,271	0			28.00
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	623,460	0			29.00
30.00	HEALTH TRACKS	192.01	0	30,328	0			30.00
31.00	PRIMARY CARE CLINIC	194.00	0	3,969	0			31.00
32.00	PARTNERS IN CARE	194.01	0	40,540	0			32.00
33.00	OCCUPATIONAL MEDICINE	194.02	0	10,573	0			33.00
34.00	SCHOOL & TOWN CLINICS	194.04	0	1,091	0			34.00
	0		0	3,744,721				
500.00	Grand Total: Decreases		1,093,870	23,676,156				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0005

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

Worksheet A-7
Part I
Date/Time Prepared:
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		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	16,574,202	4,354,009	0	4,354,009	0	1.00
2.00	Land Improvements	6,174,137	3,838,055	0	3,838,055	0	2.00
3.00	Buildings and Fixtures	246,753,868	9,402,078	0	9,402,078	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	82,661,937	26,492,431	0	26,492,431	9,498,239	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	352,164,144	44,086,573	0	44,086,573	9,498,239	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	352,164,144	44,086,573	0	44,086,573	9,498,239	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	20,928,211	0				1.00
2.00	Land Improvements	10,012,192	0				2.00
3.00	Buildings and Fixtures	256,155,946	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	99,656,129	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	386,752,478	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	386,752,478	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0005

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

Worksheet A-7
Part II
Date/Time Prepared:
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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	NEW CAP REL COSTS-BLDG & FIXT	17,994,304	0	4,864,639	262,796	0	1.00
3.00	Total (sum of lines 1-2)	17,994,304	0	4,864,639	262,796	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	NEW CAP REL COSTS-BLDG & FIXT	0	23,121,739				1.00
3.00	Total (sum of lines 1-2)	0	23,121,739				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0005

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

Worksheet A-7
Part III
Date/Time Prepared:
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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	NEW CAP REL COSTS-BLDG & FIXT	23,121,739	0	23,121,739	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	23,121,739	0	23,121,739	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	17,732,386	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	17,732,386	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	4,151,092	262,796	0	0	22,146,274	1.00
3.00	Total (sum of lines 1-2)	4,151,092	262,796	0	0	22,146,274	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0005

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

Worksheet A-8

Date/Time Prepared:
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-713,547	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00		2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-7,979,548			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	0			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	A	-767,503	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts		0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	0	28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0005

Period:
From 01/01/2016
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Worksheet A-8

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31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			31.00		
				Basis/Code (2)	Amount	Cost Center		Line #	Wkst. A-7 Ref.
32.00	CAH HIT Adjustment for Depreciation and Interest		0			0.00	0 32.00		
33.00	ADMINISTRATIVE TELEPHONE (EQUIPMENT)	A	-6,526	ADMINISTRATIVE & GENERAL		5.00	0 33.00		
33.01	ADMINISTRATIVE TELEPHONE (SALARY)	A	-24,375	ADMINISTRATIVE & GENERAL		5.00	0 33.01		
33.02	MARKETING DEPARTMENT	A	-3,053,347	ADMINISTRATIVE & GENERAL		5.00	0 33.02		
34.00	STAFF EDUCATED DEPT COURSES	B	-22,352	NURSING ADMINISTRATION		13.00	0 34.00		
35.00	CBC - OBUNITED DEPT COURSES	B	-3,100	ADULTS & PEDIATRICS		30.00	0 35.00		
36.00	EMS PROGRAM ED DEPT COURSES	B	-39,484	EMERGENCY		91.00	0 36.00		
37.00	LABORATORY MISC. SERVICES	B	-31,156	LABORATORY		60.00	0 37.00		
38.00	RADIOLOGY SALE OF X-RAYS	B	-330	RADIOLOGY-DIAGNOSTIC		54.00	0 38.00		
39.00	PHYSICAL THERAPY SUPPLIES SOLD TO OT	B	-4,576	PHYSICAL THERAPY		66.00	0 39.00		
40.00	SPORTS MEDICINE ED DEPT. COURSES	B	-31,262	PHYSICAL THERAPY		66.00	0 40.00		
41.00	PLAINFIELD PT SUPPLIES SOLD TO OTHER	B	-8,195	PHYSICAL THERAPY		66.00	0 41.00		
43.00	DIETARY CATERING	B	-14,521	CAFETERIA		11.00	0 43.00		
44.00	REGISTRATION ANSWERING SERVICE	B	-3,816	ADMINISTRATIVE & GENERAL		5.00	0 44.00		
45.00	ACCOUNTING MISCELLANEOUS/OTHER	B	-386,393	ADMINISTRATIVE & GENERAL		5.00	0 45.00		
45.01	ACCOUNTING PURCHASE DISCOUNTS TAKEN	B	-36,226	ADMINISTRATIVE & GENERAL		5.00	0 45.01		
45.02	GUEST ROOM RENTAL	B	-340	ADMINISTRATIVE & GENERAL		5.00	0 45.02		
45.03	HEALTH INFO MGMT MEDICAL RECORDS TRA	B	-1,308	MEDICAL RECORDS & LIBRARY		16.00	0 45.03		
45.04	HUMAN RESOURCES JURY DUTY RECEIPTS	B	-115	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 45.04		
45.05	MATERIALS MGMT. SUPPLIES SOLD TO OTH	B	-98	CENTRAL SERVICES & SUPPLY		14.00	0 45.05		
45.06	PLAINFIELD PT ED DEPT COURSES	B	-500	PHYSICAL THERAPY		66.00	0 45.06		
45.07	AVON ORTH/SPORT MISC./OTHER	B	-2,531	PHYSICAL THERAPY		66.00	0 45.07		
45.08	OCC THERAPY REHAB SUPPLIES SOLD TO O	B	-56	OCCUPATIONAL THERAPY		67.00	0 45.08		
45.09	HRH WELLNESSED DEPARTMENT COURSES	B	-69,289	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 45.09		
45.10	MEALS ON WHEELS	A	-392,858	DIETARY		10.00	0 45.10		
45.11	1993 CARRYFORWARD	A	-14,017	NEW CAP REL COSTS-BLDG & FIXT		1.00	9 45.11		
45.12	1994 CARRYFORWARD	A	3,288	NEW CAP REL COSTS-BLDG & FIXT		1.00	9 45.12		
45.13	PHYSICIAN RECRUITMENT	A	-693,997	ADMINISTRATIVE & GENERAL		5.00	0 45.13		
45.14	IHA LOBBYING EXPENSE	A	-4,011	ADMINISTRATIVE & GENERAL		5.00	0 45.14		
45.15	AHA LOBBYING EXPENSE	A	-5,675	ADMINISTRATIVE & GENERAL		5.00	0 45.15		
45.16	HOSPITAL ASSESSMENT FEE	A	-4,320,405	ADMINISTRATIVE & GENERAL		5.00	0 45.16		
45.17	WOUND OSTOMY LEASE REVENUE	B	-509	PHYSICAL THERAPY		66.00	9 45.17		
45.18	PHYSICAL THER ED DEPT COU	B	-36	PHYSICAL THERAPY		66.00	0 45.18		
45.21	B'BURG PT SUPPLIES SOLD T	B	-301	PHYSICAL THERAPY		66.00	9 45.21		
45.22	AVON PHYS THRPY SUPPLIES	B	-3,635	PHYSICAL THERAPY		66.00	0 45.22		
45.24	OCC THER ED DEPT CO	B	-31,307	OCCUPATIONAL THERAPY		67.00	0 45.24		
45.25	ACCOUNTING NON-OP REVENUE	B	-47,794	ADMINISTRATIVE & GENERAL		5.00	0 45.25		
45.28	HIBBELN SUR CNT MISCELLANEOUS	B	33,513	CLINIC		90.00	0 45.28		
45.29	SPEECH THERAPY MISC	B	-12,545	SPEECH PATHOLOGY		68.00	0 45.29		
45.30	MAINTENANCE MISC REVENUE	B	-163,261	OPERATION OF PLANT		7.00	0 45.30		
45.31	TRIMEDX MISC	B	-404,893	OPERATION OF PLANT		7.00	0 45.31		
45.33	QUALITY ASSURANCE MISC	B	7,500	ADMINISTRATIVE & GENERAL		5.00	0 45.33		
46.00	INTEREST EXPENSE LONG TERM CARE	A	-251,189	NEW CAP REL COSTS-BLDG & FIXT		1.00	9 46.00		
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-19,502,626				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.

Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet A-8 Date/Time Prepared: 5/30/2017 11:29 am
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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	

B. Amount Received - if cost cannot be determined.
 (3) Additional adjustments may be made on lines 33 thru 49 and subscrip ts thereof.
 Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0005

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

Worksheet A-8-2

Date/Time Prepared:
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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	30.00	ADULTS & PEDIATRICS	2,367,959	2,367,959	0	179,000	0	1.00
2.00	91.00	EMERGENCY	501,502	0	501,502	179,000	5,828	2.00
3.00	91.00	EMERGENCY	158,170	0	158,170	179,000	1,838	3.00
4.00	60.00	LABORATORY	73,282	0	73,282	260,300	586	4.00
5.00	66.00	PHYSICAL THERAPY	505,227	505,227	0	179,000	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	132,902	132,902	0	179,000	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	5,840	5,840	0	179,000	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	88,183	88,183	0	179,000	0	8.00
9.00	53.00	ANESTHESIOLOGY	4,879,437	4,879,437	0	239,400	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			8,712,502	7,979,548	732,954		8,252	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	501,544	25,077	0	0	0	2.00
3.00	91.00	EMERGENCY	158,174	7,909	0	0	0	3.00
4.00	60.00	LABORATORY	73,335	3,667	0	0	0	4.00
5.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	8.00
9.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			733,053	36,653	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	30.00	ADULTS & PEDIATRICS	0	0	0	2,367,959	1.00
2.00	91.00	EMERGENCY	0	501,544	0	0	2.00
3.00	91.00	EMERGENCY	0	158,174	0	0	3.00
4.00	60.00	LABORATORY	0	73,335	0	0	4.00
5.00	66.00	PHYSICAL THERAPY	0	0	0	505,227	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	132,902	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	5,840	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	88,183	8.00
9.00	53.00	ANESTHESIOLOGY	0	0	0	4,879,437	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	733,053	0	7,979,548	200.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prepared: 5/30/2017 11:29 am
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADM NI STRATI V E & GENERAL		
		NEW BLDG & FIXT					
	0	1.00	4.00	4A	5.00		
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	22,146,274	22,146,274			1.00	
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	6,487,256	195,201	6,682,457		4.00	
5.00 00500	ADM NI STRATI VE & GENERAL	32,977,237	1,485,481	739,219	35,201,937	5.00	
7.00 00700	OPERATION OF PLANT	9,264,197	2,230,148	164,240	11,658,585	7.00	
8.00 00800	LAUNDRY & LI NEN SERVI CE	699,481	277,667	21,552	998,700	8.00	
9.00 00900	HOUSEKEEPING	3,105,337	124,646	129,294	3,359,277	9.00	
10.00 01000	DI ETARY	576,797	489,011	30,656	1,096,464	10.00	
11.00 01100	CAFETERIA	1,507,785	86,844	72,388	1,667,017	11.00	
13.00 01300	NURSI NG ADM NI STRATI ON	2,692,729	252,766	127,031	3,072,526	13.00	
14.00 01400	CENTRAL SERVI CES & SUPPLY	1,574,876	452,259	50,139	2,077,274	14.00	
15.00 01500	PHARMACY	3,590,718	199,580	128,270	3,918,568	15.00	
16.00 01600	MEDI CAL RECORDS & LI BRARY	2,898,821	210,118	85,560	3,194,499	16.00	
17.00 01700	SOCI AL SERVI CE	2,307,399	91,952	112,327	2,511,678	17.00	
INPAT IENT ROUTI NE SERVI CE COST CENTERS							
30.00 03000	ADULTS & PEDI ATRI CS	11,519,306	2,054,271	650,112	14,223,689	30.00	
31.00 03100	I NTENSI VE CARE UNI T	2,230,274	257,204	108,882	2,596,360	31.00	
43.00 04300	NURSE RY	750,172	48,691	41,647	840,510	43.00	
ANCI LLARY SERVI CE COST CENTERS							
50.00 05000	OPERATI NG ROOM	7,662,486	485,858	98,163	8,246,507	50.00	
50.01 05001	ENDOSCOPY	1,375,556	157,165	64,109	1,596,830	50.01	
51.00 05100	RECOVERY ROOM	1,519,338	800,160	78,167	2,397,665	51.00	
52.00 05200	DELIV ERY ROOM & LABOR ROOM	1,963,683	165,135	113,113	2,241,931	52.00	
53.00 05300	ANESTHESI OLOGY	840,881	0	322,914	1,163,795	53.00	
54.00 05400	RADI OLOGY-DI AGNOSTI C	6,201,001	939,197	276,830	7,417,028	54.00	
54.01 05401	RADI ATI ON-ONCOLOGY	15,565,365	574,745	69,288	16,209,398	54.01	
56.00 03450	NUCLEAR MEDI CINE - DI AGNOSTI C	386,066	15,384	9,517	410,967	56.00	
59.00 05900	CARDI AC CATHETERI ZATI ON	789,223	268,734	36,977	1,094,934	59.00	
60.00 06000	LABORATORY	7,362,223	292,058	164,877	7,819,158	60.00	
64.00 06400	I NTRAVENOUS THERAPY	1,293,993	39,554	58,079	1,391,626	64.00	
65.00 06500	RESPI RATORY THERAPY	2,420,074	278,834	108,028	2,806,936	65.00	
66.00 06600	PHYSI CAL THERAPY	5,559,956	525,266	293,974	6,379,196	66.00	
67.00 06700	OCCUPATI ONAL THERAPY	456,359	53,712	23,708	533,779	67.00	
68.00 06800	SPEECH PATHOLOGY	383,001	69,329	19,888	472,218	68.00	
69.00 06900	ELECTROCARDI OLOGY	818,145	122,194	33,515	973,854	69.00	
69.01 06901	CARDI AC REHAB	526,684	143,037	26,119	695,840	69.01	
70.00 07000	ELECTROENCEPHALOGRAPHY	129,221	78,291	6,694	214,206	70.00	
71.00 07100	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	71.00	
72.00 07200	IMPL. DEV. CHARGED TO PATI ENT	6,733,614	0	0	6,733,614	72.00	
73.00 07300	DRUGS CHARGED TO PATI ENTS	11,308,025	0	0	11,308,025	73.00	
73.01 07301	ULTRA SOUND	651,682	19,908	28,444	700,034	73.01	
74.00 07400	RENAL DI ALYSI S	156,105	0	0	156,105	74.00	
OUTPAT IENT SERVI CE COST CENTERS							
90.00 09000	CLI NIC	5,843,641	588,611	101,988	6,534,240	90.00	
91.00 09100	EMERGENCY	4,729,550	660,130	195,687	5,585,367	91.00	
92.00 09200	OBSERVATI ON BEDS (NON-DI STI NCT PART)				0	92.00	
SPECI AL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LI NES 1-117)	189,004,531	14,733,141	4,591,396	179,500,337	25,221,051	118.00
NONRE I MBURSABLE COST CENTERS							
192.00 19200	PHYSI CI ANS' PRI VATE OFFI CES	38,555,428	6,401,455	1,698,519	46,655,402	8,154,565	192.00
192.01 19201	HEALTH TRACKS	3,805,835	362,701	186,611	4,355,147	761,210	192.01
194.00 07950	PRIM ARY CARE CLI NIC	1,855,384	324,664	57,118	2,237,166	391,021	194.00
194.01 07951	PARTNERS I N CARE	863,415	138,541	41,538	1,043,494	182,386	194.01
194.02 07952	OCCUPATI ONAL MEDI CINE	788,898	138,162	15,459	942,519	164,737	194.02
194.03 07953	FOUNDATI ON	233,787	14,099	11,488	259,374	45,334	194.03
194.04 07954	SCHOOL & TOWN CLI NICS	1,497,479	33,511	80,328	1,611,318	281,633	194.04
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	236,604,757	22,146,274	6,682,457	236,604,757	35,201,937	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0005

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2017 11:29 am

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	13,696,319				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,173,257			8.00	
9.00	00900	HOUSEKEEPING	196,154	0	4,142,579		9.00	
10.00	01000	DIETARY	769,548	0	139,720	2,197,376	10.00	
11.00	01100	CAFETERIA	136,665	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	397,774	0	32,443	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	711,712	362	79,333	0	14.00	
15.00	01500	PHARMACY	314,076	1,528	18,471	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	249,350	0	34,575	0	16.00	
17.00	01700	SOCIAL SERVICE	0	0	3,079	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,232,772	315,253	1,650,354	1,686,942	30.00	
31.00	03100	INTENSIVE CARE UNIT	404,757	44,021	143,983	190,043	31.00	
43.00	04300	NURSERY	76,624	16,707	13,025	320,391	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	764,587	78,462	289,623	0	50.00	
50.01	05001	ENDOSCOPY	247,328	43,136	7,104	0	50.01	
51.00	05100	RECOVERY ROOM	1,259,198	87,540	52,573	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	259,869	61,621	6,157	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	6,631	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	878,742	129,562	163,875	0	54.00	
54.01	05401	RADIATION-ONCOLOGY	0	8,091	94,252	0	54.01	
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	24,209	0	7,341	0	56.00	
59.00	05900	CARDIAC CATHETERIZATION	422,902	0	56,598	0	59.00	
60.00	06000	LABORATORY	394,375	141	113,434	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	62,246	4,745	8,525	0	64.00	
65.00	06500	RESPIRATORY THERAPY	381,558	0	14,919	0	65.00	
66.00	06600	PHYSICAL THERAPY	322,896	79,744	112,486	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	19,891	0	17,998	0	67.00	
68.00	06800	SPEECH PATHOLOGY	109,102	0	7,104	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	192,295	18,875	42,626	0	69.00	
69.01	06901	CARDIAC REHAB	135,792	409	18,945	0	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	123,205	989	39,548	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00	
73.01	07301	ULTRA SOUND	31,329	0	8,052	0	73.01	
74.00	07400	RENAL DIALYSIS	0	145	11,130	0	74.00	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	75,888	164,112	0	90.00	
91.00	09100	EMERGENCY	1,038,835	152,375	298,622	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00	
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,157,791	1,119,594	3,656,638	2,197,376	2,095,050	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	356,109	42,882	289,623	0	192.00	
192.01	19201	HEALTH TRACKS	0	6,934	100,172	0	192.01	
194.00	07950	PRIMARY CARE CLINIC	0	587	4,973	0	194.00	
194.01	07951	PARTNERS IN CARE	182,419	763	26,760	0	194.01	
194.02	07952	OCCUPATIONAL MEDICINE	0	2,065	60,624	0	194.02	
194.03	07953	FOUNDATION	0	0	1,658	0	194.03	
194.04	07954	SCHOOL & TOWN CLINICS	0	432	2,131	0	194.04	
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)	13,696,319	1,173,257	4,142,579	2,197,376	2,095,050	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0005

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
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	4,123,798					13.00
14.00	01400	0	3,282,515				14.00
15.00	01500	0	0	5,011,422			15.00
16.00	01600	0	0	0	4,120,904		16.00
17.00	01700	0	0	0	0	3,028,108	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,364,479	0	0	442,795	2,167,491	30.00
31.00	03100	246,302	0	0	91,749	244,240	31.00
43.00	04300	78,606	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	247,596	3,282,515	0	0	0	50.00
50.01	05001	136,105	0	0	0	0	50.01
51.00	05100	160,851	0	0	164,192	0	51.00
52.00	05200	213,319	0	0	0	0	52.00
53.00	05300	164,505	0	0	0	0	53.00
54.00	05400	559,445	0	0	852,074	0	54.00
54.01	05401	0	0	0	0	0	54.01
56.00	03450	0	0	0	0	0	56.00
59.00	05900	73,200	0	0	0	0	59.00
60.00	06000	0	0	0	870,013	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	252,320	0	0	66,688	0	65.00
66.00	06600	0	0	0	178,705	0	66.00
67.00	06700	0	0	0	28,255	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	106,446	0	0	220,777	0	69.00
69.01	06901	59,300	0	0	0	0	69.01
70.00	07000	0	0	0	0	0	70.00
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	5,011,422	0	0	73.00
73.01	07301	0	0	0	0	0	73.01
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	461,324	0	0	1,205,656	616,377	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		4,123,798	3,282,515	5,011,422	4,120,904	3,028,108	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	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
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		4,123,798	3,282,515	5,011,422	4,120,904	3,028,108	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prepared: 5/30/2017 11:29 am
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
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
17.00	01700	SOCIAL SERVICE			17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	27,982,477	0	27,982,477
31.00	03100	INTENSIVE CARE UNIT	4,489,741	0	4,489,741
43.00	04300	NURSERY	1,516,542	0	1,516,542
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	14,425,522	0	14,425,522
50.01	05001	ENDOSCOPY	2,350,762	0	2,350,762
51.00	05100	RECOVERY ROOM	4,589,735	0	4,589,735
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,239,260	0	3,239,260
53.00	05300	ANESTHESIOLOGY	1,588,092	0	1,588,092
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,466,285	0	11,466,285
54.01	05401	RADIATION-ONCOLOGY	19,194,022	0	19,194,022
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	519,616	0	519,616
59.00	05900	CARDIAC CATHETERIZATION	1,861,147	0	1,861,147
60.00	06000	LABORATORY	10,713,476	0	10,713,476
64.00	06400	INTRAVENOUS THERAPY	1,742,422	0	1,742,422
65.00	06500	RESPIRATORY THERAPY	4,089,333	0	4,089,333
66.00	06600	PHYSICAL THERAPY	8,386,785	0	8,386,785
67.00	06700	OCCUPATIONAL THERAPY	708,418	0	708,418
68.00	06800	SPEECH PATHOLOGY	682,648	0	682,648
69.00	06900	ELECTROCARDIOLOGY	1,757,277	0	1,757,277
69.01	06901	CARDIAC REHAB	1,049,841	0	1,049,841
70.00	07000	ELECTROENCEPHALOGRAPHY	420,527	0	420,527
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,910,542	0	7,910,542
73.00	07300	DRUGS CHARGED TO PATIENTS	18,295,909	0	18,295,909
73.01	07301	ULTRA SOUND	875,657	0	875,657
74.00	07400	RENAL DIALYSIS	194,665	0	194,665
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	7,916,321	0	7,916,321
91.00	09100	EMERGENCY	10,474,297	0	10,474,297
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	168,441,319	0	168,441,319
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	55,498,581	0	55,498,581
192.01	19201	HEALTH TRACKS	5,223,463	0	5,223,463
194.00	07950	PRIMARY CARE CLINIC	2,633,747	0	2,633,747
194.01	07951	PARTNERS IN CARE	1,435,822	0	1,435,822
194.02	07952	OCCUPATIONAL MEDICINE	1,169,945	0	1,169,945
194.03	07953	FOUNDATION	306,366	0	306,366
194.04	07954	SCHOOL & TOWN CLINICS	1,895,514	0	1,895,514
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118-201)	236,604,757	0	236,604,757

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/30/2017 11:29 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	195,201	195,201	195,201	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,485,481	1,485,481	21,593	5.00
7.00	00700	OPERATION OF PLANT	0	2,230,148	2,230,148	4,797	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	277,667	277,667	630	8.00
9.00	00900	HOUSEKEEPING	0	124,646	124,646	3,777	9.00
10.00	01000	DIETARY	0	489,011	489,011	895	10.00
11.00	01100	CAFETERIA	0	86,844	86,844	2,114	11.00
13.00	01300	NURSING ADMINISTRATION	0	252,766	252,766	3,711	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	452,259	452,259	1,465	14.00
15.00	01500	PHARMACY	0	199,580	199,580	3,747	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	210,118	210,118	2,499	16.00
17.00	01700	SOCIAL SERVICE	0	91,952	91,952	3,281	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	2,054,271	2,054,271	18,990	30.00
31.00	03100	INTENSIVE CARE UNIT	0	257,204	257,204	3,180	31.00
43.00	04300	NURSERY	0	48,691	48,691	1,217	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	485,858	485,858	2,867	50.00
50.01	05001	ENDOSCOPY	0	157,165	157,165	11,873	50.01
51.00	05100	RECOVERY ROOM	0	800,160	800,160	2,283	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	165,135	165,135	3,304	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	9,432	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	939,197	939,197	8,086	54.00
54.01	05401	RADIATION-ONCOLOGY	0	574,745	574,745	2,024	54.01
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	15,384	15,384	278	56.00
59.00	05900	CARDIAC CATHETERIZATION	0	268,734	268,734	1,080	59.00
60.00	06000	LABORATORY	0	292,058	292,058	4,816	60.00
64.00	06400	INTRAVENOUS THERAPY	0	39,554	39,554	1,696	64.00
65.00	06500	RESPIRATORY THERAPY	0	278,834	278,834	3,155	65.00
66.00	06600	PHYSICAL THERAPY	0	525,266	525,266	8,587	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	53,712	53,712	693	67.00
68.00	06800	SPEECH PATHOLOGY	0	69,329	69,329	581	68.00
69.00	06900	ELECTROCARDIOLOGY	0	122,194	122,194	797	69.00
69.01	06901	CARDIAC REHAB	0	143,037	143,037	763	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	78,291	78,291	196	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	07301	ULTRA SOUND	0	19,908	19,908	831	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	588,611	588,611	2,979	90.00
91.00	09100	EMERGENCY	0	660,130	660,130	5,716	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	14,733,141	14,733,141	134,115	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,401,455	6,401,455	49,620	192.00
192.01	19201	HEALTH TRACKS	0	362,701	362,701	5,451	192.01
194.00	07950	PRIMARY CARE CLINIC	0	324,664	324,664	1,668	194.00
194.01	07951	PARTNERS IN CARE	0	138,541	138,541	1,213	194.01
194.02	07952	OCCUPATIONAL MEDICINE	0	138,162	138,162	452	194.02
194.03	07953	FOUNDATION	0	14,099	14,099	336	194.03
194.04	07954	SCHOOL & TOWN CLINICS	0	33,511	33,511	2,346	194.04
200.00		Cross Foot Adjustments			0		200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	22,146,274	22,146,274	195,201	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-0005		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 5/30/2017 11:29 am	
Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	2,322,186					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	285,770				8.00
9.00	00900	HOUSEKEEPING	33,258	0	186,818			9.00
10.00	01000	DIETARY	130,475	0	6,301	634,887		10.00
11.00	01100	CAFETERIA	23,171	0	0	0	124,603	11.00
13.00	01300	NURSING ADMINISTRATION	67,442	0	1,463	0	4,997	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	120,670	88	3,578	0	3,019	14.00
15.00	01500	PHARMACY	53,251	372	833	0	4,394	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	42,277	0	1,559	0	5,004	16.00
17.00	01700	SOCIAL SERVICE	0	0	139	0	4,422	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	548,110	76,787	74,429	487,408	24,539	30.00
31.00	03100	INTENSIVE CARE UNIT	68,626	10,722	6,493	54,909	4,430	31.00
43.00	04300	NURSERY	12,991	4,069	587	92,570	1,414	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	129,634	19,111	13,061	0	4,453	50.00
50.01	05001	ENDOSCOPY	41,934	10,507	320	0	2,448	50.01
51.00	05100	RECOVERY ROOM	213,495	21,322	2,371	0	2,893	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	44,060	15,009	278	0	3,837	52.00
53.00	05300	ANESTHESIOLOGY	0	0	299	0	2,959	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	148,989	31,557	7,390	0	10,062	54.00
54.01	05401	RADIATION-ONCOLOGY	0	1,971	4,250	0	2,923	54.01
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	4,105	0	331	0	313	56.00
59.00	05900	CARDIAC CATHETERIZATION	71,702	0	2,552	0	1,317	59.00
60.00	06000	LABORATORY	66,866	34	5,116	0	8,903	60.00
64.00	06400	INTRAVENOUS THERAPY	10,554	1,156	384	0	1,906	64.00
65.00	06500	RESPIRATORY THERAPY	64,693	0	673	0	4,538	65.00
66.00	06600	PHYSICAL THERAPY	54,746	19,423	5,073	0	11,822	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,372	0	812	0	904	67.00
68.00	06800	SPEECH PATHOLOGY	18,498	0	320	0	695	68.00
69.00	06900	ELECTROCARDIOLOGY	32,603	4,597	1,922	0	1,915	69.00
69.01	06901	CARDIAC REHAB	23,023	100	854	0	1,067	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	20,889	241	1,783	0	306	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ULTRA SOUND	5,312	0	363	0	826	73.01
74.00	07400	RENAL DIALYSIS	0	35	502	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	18,484	7,401	0	0	90.00
91.00	09100	EMERGENCY	176,133	37,114	13,467	0	8,297	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,230,879	272,699	164,904	634,887	124,603	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	60,378	10,445	13,061	0	0	192.00
192.01	19201	HEALTH TRACKS	0	1,689	4,517	0	0	192.01
194.00	07950	PRIMARY CARE CLINIC	0	143	224	0	0	194.00
194.01	07951	PARTNERS IN CARE	30,929	186	1,207	0	0	194.01
194.02	07952	OCCUPATIONAL MEDICINE	0	503	2,734	0	0	194.02
194.03	07953	FOUNDATION	0	0	75	0	0	194.03
194.04	07954	SCHOOL & TOWN CLINICS	0	105	96	0	0	194.04
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)	2,322,186	285,770	186,818	634,887	124,603	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/30/2017 11:29 am
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Cost Center Description		NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
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	353,371					13.00
14.00	01400	0	596,623				14.00
15.00	01500	0	0	291,500			15.00
16.00	01600	0	0	0	285,361		16.00
17.00	01700	0	0	0	0	118,589	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	116,923	0	0	30,649	84,885	30.00
31.00	03100	21,106	0	0	6,351	9,565	31.00
43.00	04300	6,736	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	21,217	596,623	0	0	0	50.00
50.01	05001	11,663	0	0	0	0	50.01
51.00	05100	13,783	0	0	11,365	0	51.00
52.00	05200	18,279	0	0	0	0	52.00
53.00	05300	14,097	0	0	0	0	53.00
54.00	05400	47,939	0	0	58,978	0	54.00
54.01	05401	0	0	0	0	0	54.01
56.00	03450	0	0	0	0	0	56.00
59.00	05900	6,273	0	0	0	0	59.00
60.00	06000	0	0	0	60,220	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	21,622	0	0	4,616	0	65.00
66.00	06600	0	0	0	12,369	0	66.00
67.00	06700	0	0	0	1,956	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	9,121	0	0	15,282	0	69.00
69.01	06901	5,081	0	0	0	0	69.01
70.00	07000	0	0	0	0	0	70.00
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	291,500	0	0	73.00
73.01	07301	0	0	0	0	0	73.01
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	39,531	0	0	83,575	24,139	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		353,371	596,623	291,500	285,361	118,589	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	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
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		353,371	596,623	291,500	285,361	118,589	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/30/2017 11:29 am
Cost Center	Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
		24.00	25.00	26.00
GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT			1.00
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
17.00	01700 SOCIAL SERVICE			17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	3,623,427	0	3,623,427
31.00	03100 INTENSIVE CARE UNIT	462,015	0	462,015
43.00	04300 NURSERY	174,565	0	174,565
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	1,334,533	0	1,334,533
50.01	05001 ENDOSCOPY	237,859	0	237,859
51.00	05100 RECOVERY ROOM	1,085,614	0	1,085,614
52.00	05200 DELIVERY ROOM & LABOR ROOM	266,678	0	266,678
53.00	05300 ANESTHESIOLOGY	35,496	0	35,496
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,307,700	0	1,307,700
54.01	05401 RADIOLOGY-ONCOLOGY	707,208	0	707,208
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	23,486	0	23,486
59.00	05900 CARDIAC CATHETERIZATION	359,851	0	359,851
60.00	06000 LABORATORY	496,524	0	496,524
64.00	06400 INTRAVENOUS THERAPY	65,664	0	65,664
65.00	06500 RESPIRATORY THERAPY	399,135	0	399,135
66.00	06600 PHYSICAL THERAPY	685,022	0	685,022
67.00	06700 OCCUPATIONAL THERAPY	65,443	0	65,443
68.00	06800 SPEECH PATHOLOGY	92,957	0	92,957
69.00	06900 ELECTROCARDIOLOGY	195,900	0	195,900
69.01	06901 CARDIAC REHAB	179,132	0	179,132
70.00	07000 ELECTROENCEPHALOGRAPHY	103,309	0	103,309
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	50,388	0	50,388
73.00	07300 DRUGS CHARGED TO PATIENTS	376,118	0	376,118
73.01	07301 ULTRA SOUND	32,478	0	32,478
74.00	07400 RENAL DIALYSIS	1,705	0	1,705
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	666,371	0	666,371
91.00	09100 EMERGENCY	1,089,897	0	1,089,897
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0	
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	14,118,475	0	14,118,475
NONREIMBURSABLE COST CENTERS				
192.00	19200 PHYSICIANS' PRIVATE OFFICES	6,884,057	0	6,884,057
192.01	19201 HEALTH TRACKS	406,948	0	406,948
194.00	07950 PRIMARY CARE CLINIC	343,440	0	343,440
194.01	07951 PARTNERS IN CARE	179,884	0	179,884
194.02	07952 OCCUPATIONAL MEDICINE	148,904	0	148,904
194.03	07953 FOUNDATION	16,451	0	16,451
194.04	07954 SCHOOL & TOWN CLINICS	48,115	0	48,115
200.00	Cross Foot Adjustments	0	0	0
201.00	Negative Cost Centers	0	0	0
202.00	TOTAL (sum lines 118-201)	22,146,274	0	22,146,274

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0005

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

Worksheet B-1
Date/Time Prepared:
5/30/2017 11:29 am

Cost Center Description	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci liatio n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)		
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00	4.00	5A	5.00	7.00		
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	758,663					1.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	6,687	100,980,803				4.00	
5.00 00500 ADMINI STRATI VE & GENERAL	50,888	11,170,498	-35,201,937	201,402,820		5.00	
7.00 00700 OPERATION OF PLANT	76,398	2,481,870	0	11,658,585	298,150	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	9,512	325,676	0	998,700	0	8.00	
9.00 00900 HOUSEKEEPING	4,270	1,953,789	0	3,359,277	4,270	9.00	
10.00 01000 DI ETARY	16,752	463,254	0	1,096,464	16,752	10.00	
11.00 01100 CAFETERIA	2,975	1,093,870	0	1,667,017	2,975	11.00	
13.00 01300 NURSI NG ADMI NI STRATION	8,659	1,919,592	0	3,072,526	8,659	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	15,493	757,668	0	2,077,274	15,493	14.00	
15.00 01500 PHARMACY	6,837	1,938,321	0	3,918,568	6,837	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	7,198	1,292,912	0	3,194,499	5,428	16.00	
17.00 01700 SOCIAL SERVICE	3,150	1,697,391	0	2,511,678	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	70,373	9,823,979	0	14,223,689	70,373	30.00	
31.00 03100 INTENSIVE CARE UNIT	8,811	1,645,336	0	2,596,360	8,811	31.00	
43.00 04300 NURSERY	1,668	629,342	0	840,510	1,668	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	16,644	1,483,368	0	8,246,507	16,644	50.00	
50.01 05001 ENDOSCOPY	5,384	968,764	0	1,596,830	5,384	50.01	
51.00 05100 RECOVERY ROOM	27,411	1,181,195	0	2,397,665	27,411	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	5,657	1,709,270	0	2,241,931	5,657	52.00	
53.00 05300 ANESTHESIOLOGY	0	4,879,621	0	1,163,795	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	32,174	4,183,237	0	7,417,028	19,129	54.00	
54.01 05401 RADIOLOGY-ONCOLOGY	19,689	1,047,020	0	16,209,398	0	54.01	
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	527	143,807	0	410,967	527	56.00	
59.00 05900 CARDIAC CATHETERIZATION	9,206	558,767	0	1,094,934	9,206	59.00	
60.00 06000 LABORATORY	10,005	2,491,499	0	7,819,158	8,585	60.00	
64.00 06400 INTRAVENOUS THERAPY	1,355	877,639	0	1,391,626	1,355	64.00	
65.00 06500 RESPIRATORY THERAPY	9,552	1,632,433	0	2,806,936	8,306	65.00	
66.00 06600 PHYSICAL THERAPY	17,994	4,442,301	0	6,379,196	7,029	66.00	
67.00 06700 OCCUPATIONAL THERAPY	1,840	358,262	0	533,779	433	67.00	
68.00 06800 SPEECH PATHOLOGY	2,375	300,538	0	472,218	2,375	68.00	
69.00 06900 ELECTROCARDIOLOGY	4,186	506,456	0	973,854	4,186	69.00	
69.01 06901 CARDIAC REHAB	4,900	394,690	0	695,840	2,956	69.01	
70.00 07000 ELECTROENCEPHALOGRAPHY	2,682	101,147	0	214,206	2,682	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	6,733,614	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	11,308,025	0	73.00	
73.01 07301 ULTRA SOUND	682	429,827	0	700,034	682	73.01	
74.00 07400 RENAL DIALYSIS	0	0	0	156,105	0	74.00	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	20,164	1,541,158	0	6,534,240	0	90.00	
91.00 09100 EMERGENCY	22,614	2,957,062	0	5,585,367	22,614	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	504,712	69,381,559	-35,201,937	144,298,400	286,427	118.00
NONREIMBURSABLE COST CENTERS							
192.00 19200 PHYSICIANS' PRIVATE OFFICES	219,294	25,667,448	0	46,655,402	7,752	192.00	
192.01 19201 HEALTH TRACKS	12,425	2,819,924	0	4,355,147	0	192.01	
194.00 07950 PRIMARY CARE CLINIC	11,122	863,130	0	2,237,166	0	194.00	
194.01 07951 PARTNERS IN CARE	4,746	627,693	0	1,043,494	3,971	194.01	
194.02 07952 OCCUPATIONAL MEDICINE	4,733	233,599	0	942,519	0	194.02	
194.03 07953 FOUNDATION	483	173,600	0	259,374	0	194.03	
194.04 07954 SCHOOL & TOWN CLINICS	1,148	1,213,850	0	1,611,318	0	194.04	
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)	22,146,274	6,682,457		35,201,937	13,696,319	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	29.191188	0.066176		0.174784	45.937679	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		195,201		1,507,074	2,322,186	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.001933		0.007483	7.788650	205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0005		Period: From 01/01/2016 To 12/31/2016		Worksheet B-1	
Date/Time Prepared: 5/30/2017 11:29 am							
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)		
	8.00	9.00	10.00	11.00	13.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
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	891,311				8.00
9.00	00900	HOUSEKEEPING	0	17,493			9.00
10.00	01000	DIETARY	0	590	21,460		10.00
11.00	01100	CAFETERIA	0	0	0	1,423,905	11.00
13.00	01300	NURSING ADMINISTRATION	0	137	0	57,109	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	275	335	0	34,499	14.00
15.00	01500	PHARMACY	1,161	78	0	50,210	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	146	0	57,181	16.00
17.00	01700	SOCIAL SERVICE	0	13	0	50,532	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	239,493	6,969	16,475	280,445	30.00
31.00	03100	INTENSIVE CARE UNIT	33,442	608	1,856	50,623	31.00
43.00	04300	NURSERY	12,692	55	3,129	16,156	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	59,607	1,223	0	50,889	50.00
50.01	05001	ENDOSCOPY	32,770	30	0	27,974	50.01
51.00	05100	RECOVERY ROOM	66,503	222	0	33,060	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	46,813	26	0	43,844	52.00
53.00	05300	ANESTHESIOLOGY	0	28	0	33,811	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	98,427	692	0	114,984	54.00
54.01	05401	RADIATION-ONCOLOGY	6,147	398	0	33,397	54.01
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	31	0	3,581	56.00
59.00	05900	CARDIAC CATHETERIZATION	0	239	0	15,045	59.00
60.00	06000	LABORATORY	107	479	0	101,738	60.00
64.00	06400	INTRAVENOUS THERAPY	3,605	36	0	21,780	64.00
65.00	06500	RESPIRATORY THERAPY	0	63	0	51,860	65.00
66.00	06600	PHYSICAL THERAPY	60,581	475	0	135,099	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	76	0	10,330	67.00
68.00	06800	SPEECH PATHOLOGY	0	30	0	7,944	68.00
69.00	06900	ELECTROCARDIOLOGY	14,339	180	0	21,878	69.00
69.01	06901	CARDIAC REHAB	311	80	0	12,188	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	751	167	0	3,493	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	07301	ULTRA SOUND	0	34	0	9,438	73.01
74.00	07400	RENAL DIALYSIS	110	47	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	57,651	693	0	0	90.00
91.00	09100	EMERGENCY	115,758	1,261	0	94,817	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	850,543	15,441	21,460	1,423,905	847,574
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	32,577	1,223	0	0	192.00
192.01	19201	HEALTH TRACKS	5,268	423	0	0	192.01
194.00	07950	PRIMARY CARE CLINIC	446	21	0	0	194.00
194.01	07951	PARTNERS IN CARE	580	113	0	0	194.01
194.02	07952	OCCUPATIONAL MEDICINE	1,569	256	0	0	194.02
194.03	07953	FOUNDATION	0	7	0	0	194.03
194.04	07954	SCHOOL & TOWN CLINICS	328	9	0	0	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,173,257	4,142,579	2,197,376	2,095,050	4,123,798
203.00		Unit cost multiplier (Wkst. B, Part I)	1.316327	236.813525	102.394035	1.471341	4.865414
204.00		Cost to be allocated (per Wkst. B, Part II)	285,770	186,818	634,887	124,603	353,371
205.00		Unit cost multiplier (Wkst. B, Part II)	0.320618	10.679586	29.584669	0.087508	0.416921

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet B-1 Date/Time Prepared: 5/30/2017 11:29 am
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Cost Center Description		CENTRAL SERVICES & SUPPLY (100% ALLOCATION)	PHARMACY (100% ALLOCATION)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
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	100			14.00
15.00	01500	PHARMACY	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	263,618,141	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	28,326,194	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	5,869,321	31.00
43.00	04300	NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	100	0	0	50.00
50.01	05001	ENDOSCOPY	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	10,503,567	51.00
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	54,508,342	54.00
54.01	05401	RADIATION-ONCOLOGY	0	0	0	54.01
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	56.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	0	55,655,871	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	4,266,104	65.00
66.00	06600	PHYSICAL THERAPY	0	0	11,432,008	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,807,516	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	14,123,412	69.00
69.01	06901	CARDIAC REHAB	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	0	73.00
73.01	07301	ULTRA SOUND	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	77,125,806	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	100	263,618,141	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
192.01	19201	HEALTH TRACKS	0	0	0	192.01
194.00	07950	PRIMARY CARE CLINIC	0	0	0	194.00
194.01	07951	PARTNERS IN CARE	0	0	0	194.01
194.02	07952	OCCUPATIONAL MEDICINE	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	194.03
194.04	07954	SCHOOL & TOWN CLINICS	0	0	0	194.04
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)	3,282,515	5,011,422	4,120,904	3,028,108
203.00		Unit cost multiplier (Wkst. B, Part I)	32,825.150000	50,114.220000	0.015632	154.094346
204.00		Cost to be allocated (per Wkst. B, Part II)	596,623	291,500	285,361	118,589
205.00		Unit cost multiplier (Wkst. B, Part II)	5,966.230000	2,915.000000	0.001082	6.034757

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0005

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

Worksheet C
Part I
Date/Time Prepared:
5/30/2017 11:29 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	27,982,477		27,982,477	0	27,982,477	30.00
31.00	03100 INTENSIVE CARE UNIT	4,489,741		4,489,741	0	4,489,741	31.00
43.00	04300 NURSERY	1,516,542		1,516,542	0	1,516,542	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	14,425,522		14,425,522	0	14,425,522	50.00
50.01	05001 ENDOSCOPY	2,350,762		2,350,762	0	2,350,762	50.01
51.00	05100 RECOVERY ROOM	4,589,735		4,589,735	0	4,589,735	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3,239,260		3,239,260	0	3,239,260	52.00
53.00	05300 ANESTHESIOLOGY	1,588,092		1,588,092	0	1,588,092	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	11,466,285		11,466,285	0	11,466,285	54.00
54.01	05401 RADIATION-ONCOLOGY	19,194,022		19,194,022	0	19,194,022	54.01
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	519,616		519,616	0	519,616	56.00
59.00	05900 CARDIAC CATHETERIZATION	1,861,147		1,861,147	0	1,861,147	59.00
60.00	06000 LABORATORY	10,713,476		10,713,476	0	10,713,476	60.00
64.00	06400 INTRAVENOUS THERAPY	1,742,422		1,742,422	0	1,742,422	64.00
65.00	06500 RESPIRATORY THERAPY	4,089,333	0	4,089,333	0	4,089,333	65.00
66.00	06600 PHYSICAL THERAPY	8,386,785	0	8,386,785	0	8,386,785	66.00
67.00	06700 OCCUPATIONAL THERAPY	708,418	0	708,418	0	708,418	67.00
68.00	06800 SPEECH PATHOLOGY	682,648	0	682,648	0	682,648	68.00
69.00	06900 ELECTROCARDIOLOGY	1,757,277		1,757,277	0	1,757,277	69.00
69.01	06901 CARDIAC REHAB	1,049,841		1,049,841	0	1,049,841	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	420,527		420,527	0	420,527	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	7,910,542		7,910,542	0	7,910,542	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	18,295,909		18,295,909	0	18,295,909	73.00
73.01	07301 ULTRA SOUND	875,657		875,657	0	875,657	73.01
74.00	07400 RENAL DIALYSIS	194,665		194,665	0	194,665	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	7,916,321		7,916,321	0	7,916,321	90.00
91.00	09100 EMERGENCY	10,474,297		10,474,297	0	10,474,297	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,943,579		4,943,579	0	4,943,579	92.00
200.00	Subtotal (see instructions)	173,384,898	0	173,384,898	0	173,384,898	200.00
201.00	Less Observation Beds	4,943,579		4,943,579	0	4,943,579	201.00
202.00	Total (see instructions)	168,441,319	0	168,441,319	0	168,441,319	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0005

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

Worksheet C
Part I
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			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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,496,525		21,496,525			30.00
31.00	03100	INTENSIVE CARE UNIT	5,318,363		5,318,363			31.00
43.00	04300	NURSERY	6,162,996		6,162,996			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	17,542,784	26,313,306	43,856,090	0.328929	0.000000	50.00
50.01	05001	ENDOSCOPY	695,404	11,893,971	12,589,375	0.186726	0.000000	50.01
51.00	05100	RECOVERY ROOM	3,467,785	7,035,782	10,503,567	0.436969	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,658,775	170,384	10,829,159	0.299124	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,197,855	5,736,210	9,934,065	0.159863	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,413,749	46,655,815	54,069,564	0.212065	0.000000	54.00
54.01	05401	RADIATION-ONCOLOGY	391,090	57,591,766	57,982,856	0.331029	0.000000	54.01
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	477,758	4,719,553	5,197,311	0.099978	0.000000	56.00
59.00	05900	CARDIAC CATHETERIZATION	5,517,579	11,431,404	16,948,983	0.109809	0.000000	59.00
60.00	06000	LABORATORY	10,876,690	45,369,056	56,245,746	0.190476	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	168,214	7,284,203	7,452,417	0.233806	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,974,083	1,291,531	4,265,614	0.958674	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,629,041	9,751,324	11,380,365	0.736952	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	836,031	869,263	1,705,294	0.415423	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	344,932	1,466,526	1,811,458	0.376850	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,475,271	11,468,371	13,943,642	0.126027	0.000000	69.00
69.01	06901	CARDIAC REHAB	27,156	1,815,266	1,842,422	0.569816	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	130,611	707,064	837,675	0.502017	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,940,319	4,355,758	13,296,077	0.594953	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,680,178	18,071,176	27,751,354	0.659280	0.000000	73.00
73.01	07301	ULTRA SOUND	1,974,236	9,774,725	11,748,961	0.074531	0.000000	73.01
74.00	07400	RENAL DIALYSIS	241,887	13,345	255,232	0.762698	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	30,261	38,091,587	38,121,848	0.207658	0.000000	90.00
91.00	09100	EMERGENCY	13,977,297	63,004,719	76,982,016	0.136062	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,789,273	3,789,273	1.304625	0.000000	92.00
200.00		Subtotal (see instructions)	137,646,870	388,671,378	526,318,248			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	137,646,870	388,671,378	526,318,248			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/30/2017 11:29 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.328929		50.00
50.01	05001 ENDOSCOPY	0.186726		50.01
51.00	05100 RECOVERY ROOM	0.436969		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.299124		52.00
53.00	05300 ANESTHESIOLOGY	0.159863		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.212065		54.00
54.01	05401 RADIATION-ONCOLOGY	0.331029		54.01
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.099978		56.00
59.00	05900 CARDIAC CATHETERIZATION	0.109809		59.00
60.00	06000 LABORATORY	0.190476		60.00
64.00	06400 INTRAVENOUS THERAPY	0.233806		64.00
65.00	06500 RESPIRATORY THERAPY	0.958674		65.00
66.00	06600 PHYSICAL THERAPY	0.736952		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.415423		67.00
68.00	06800 SPEECH PATHOLOGY	0.376850		68.00
69.00	06900 ELECTROCARDIOLOGY	0.126027		69.00
69.01	06901 CARDIAC REHAB	0.569816		69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.502017		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.594953		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.659280		73.00
73.01	07301 ULTRA SOUND	0.074531		73.01
74.00	07400 RENAL DIALYSIS	0.762698		74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.207658		90.00
91.00	09100 EMERGENCY	0.136062		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.304625		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: 15-0005

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	27,982,477		27,982,477	0	27,982,477	30.00
31.00	03100 INTENSIVE CARE UNIT	4,489,741		4,489,741	0	4,489,741	31.00
43.00	04300 NURSERY	1,516,542		1,516,542	0	1,516,542	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	14,425,522		14,425,522	0	14,425,522	50.00
50.01	05001 ENDOSCOPY	2,350,762		2,350,762	0	2,350,762	50.01
51.00	05100 RECOVERY ROOM	4,589,735		4,589,735	0	4,589,735	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3,239,260		3,239,260	0	3,239,260	52.00
53.00	05300 ANESTHESIOLOGY	1,588,092		1,588,092	0	1,588,092	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	11,466,285		11,466,285	0	11,466,285	54.00
54.01	05401 RADIATION-ONCOLOGY	19,194,022		19,194,022	0	19,194,022	54.01
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	519,616		519,616	0	519,616	56.00
59.00	05900 CARDIAC CATHETERIZATION	1,861,147		1,861,147	0	1,861,147	59.00
60.00	06000 LABORATORY	10,713,476		10,713,476	0	10,713,476	60.00
64.00	06400 INTRAVENOUS THERAPY	1,742,422		1,742,422	0	1,742,422	64.00
65.00	06500 RESPIRATORY THERAPY	4,089,333	0	4,089,333	0	4,089,333	65.00
66.00	06600 PHYSICAL THERAPY	8,386,785	0	8,386,785	0	8,386,785	66.00
67.00	06700 OCCUPATIONAL THERAPY	708,418	0	708,418	0	708,418	67.00
68.00	06800 SPEECH PATHOLOGY	682,648	0	682,648	0	682,648	68.00
69.00	06900 ELECTROCARDIOLOGY	1,757,277		1,757,277	0	1,757,277	69.00
69.01	06901 CARDIAC REHAB	1,049,841		1,049,841	0	1,049,841	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	420,527		420,527	0	420,527	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	7,910,542		7,910,542	0	7,910,542	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	18,295,909		18,295,909	0	18,295,909	73.00
73.01	07301 ULTRA SOUND	875,657		875,657	0	875,657	73.01
74.00	07400 RENAL DIALYSIS	194,665		194,665	0	194,665	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	7,916,321		7,916,321	0	7,916,321	90.00
91.00	09100 EMERGENCY	10,474,297		10,474,297	0	10,474,297	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,943,579		4,943,579	0	4,943,579	92.00
200.00	Subtotal (see instructions)	173,384,898	0	173,384,898	0	173,384,898	200.00
201.00	Less Observation Beds	4,943,579		4,943,579	0	4,943,579	201.00
202.00	Total (see instructions)	168,441,319	0	168,441,319	0	168,441,319	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/30/2017 11:29 am
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Cost Center Description		Title XIX			Hospital	Cost	
		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			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	21,496,525		21,496,525		30.00
31.00	03100	INTENSIVE CARE UNIT	5,318,363		5,318,363		31.00
43.00	04300	NURSERY	6,162,996		6,162,996		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	17,542,784	26,313,306	43,856,090	0.328929	50.00
50.01	05001	ENDOSCOPY	695,404	11,893,971	12,589,375	0.186726	50.01
51.00	05100	RECOVERY ROOM	3,467,785	7,035,782	10,503,567	0.436969	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,658,775	170,384	10,829,159	0.299124	52.00
53.00	05300	ANESTHESIOLOGY	4,197,855	5,736,210	9,934,065	0.159863	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,413,749	46,655,815	54,069,564	0.212065	54.00
54.01	05401	RADIATION-ONCOLOGY	391,090	57,591,766	57,982,856	0.331029	54.01
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	477,758	4,719,553	5,197,311	0.099978	56.00
59.00	05900	CARDIAC CATHETERIZATION	5,517,579	11,431,404	16,948,983	0.109809	59.00
60.00	06000	LABORATORY	10,876,690	45,369,056	56,245,746	0.190476	60.00
64.00	06400	INTRAVENOUS THERAPY	168,214	7,284,203	7,452,417	0.233806	64.00
65.00	06500	RESPIRATORY THERAPY	2,974,083	1,291,531	4,265,614	0.958674	65.00
66.00	06600	PHYSICAL THERAPY	1,629,041	9,751,324	11,380,365	0.736952	66.00
67.00	06700	OCCUPATIONAL THERAPY	836,031	869,263	1,705,294	0.415423	67.00
68.00	06800	SPEECH PATHOLOGY	344,932	1,466,526	1,811,458	0.376850	68.00
69.00	06900	ELECTROCARDIOLOGY	2,475,271	11,468,371	13,943,642	0.126027	69.00
69.01	06901	CARDIAC REHAB	27,156	1,815,266	1,842,422	0.569816	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	130,611	707,064	837,675	0.502017	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,940,319	4,355,758	13,296,077	0.594953	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,680,178	18,071,176	27,751,354	0.659280	73.00
73.01	07301	ULTRA SOUND	1,974,236	9,774,725	11,748,961	0.074531	73.01
74.00	07400	RENAL DIALYSIS	241,887	13,345	255,232	0.762698	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	30,261	38,091,587	38,121,848	0.207658	90.00
91.00	09100	EMERGENCY	13,977,297	63,004,719	76,982,016	0.136062	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,789,273	3,789,273	1.304625	92.00
200.00		Subtotal (see instructions)	137,646,870	388,671,378	526,318,248		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	137,646,870	388,671,378	526,318,248		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/30/2017 11:29 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital
		11.00		Cost
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
50.01	05001 ENDOSCOPY	0.000000		50.01
51.00	05100 RECOVERY ROOM	0.000000		51.00
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 RADIATION-ONCOLOGY	0.000000		54.01
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.000000		56.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901 CARDIAC REHAB	0.000000		69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301 ULTRA SOUND	0.000000		73.01
74.00	07400 RENAL DIALYSIS	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
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: 15-0005		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part I Date/Time Prepared: 5/30/2017 11:29 am		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
Title XVIII		Hospital		PPS				
Cost Center Description		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	3,623,427	0	3,623,427	19,449	186.30	30.00	
31.00	INTENSIVE CARE UNIT	462,015		462,015	1,856	248.93	31.00	
43.00	NURSERY	174,565		174,565	3,129	55.79	43.00	
200.00	Total (Lines 30-199)	4,260,007		4,260,007	24,434		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	6,382	1,188,967					30.00
31.00	INTENSIVE CARE UNIT	855	212,835					31.00
43.00	NURSERY	0	0					43.00
200.00	Total (Lines 30-199)	7,237	1,401,802					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Prepared: 5/30/2017 11:29 am
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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		Capital Costs (column 3 x column 4)	
					Inpatient Program Charges	PPS		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,334,533	43,856,090	0.030430	7,206,950	219,307	50.00
50.01	05001	ENDOSCOPY	237,859	12,589,375	0.018894	0	0	50.01
51.00	05100	RECOVERY ROOM	1,085,614	10,503,567	0.103357	1,190,368	123,033	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	266,678	10,829,159	0.024626	13,170	324	52.00
53.00	05300	ANESTHESIOLOGY	35,496	9,934,065	0.003573	1,501,310	5,364	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,307,700	54,069,564	0.024186	3,747,326	90,633	54.00
54.01	05401	RADIATION-ONCOLOGY	707,208	57,982,856	0.012197	169,228	2,064	54.01
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	23,486	5,197,311	0.004519	253,056	1,144	56.00
59.00	05900	CARDIAC CATHETERIZATION	359,851	16,948,983	0.021231	2,421,516	51,411	59.00
60.00	06000	LABORATORY	496,524	56,245,746	0.008828	5,038,874	44,483	60.00
64.00	06400	INTRAVENOUS THERAPY	65,664	7,452,417	0.008811	119,854	1,056	64.00
65.00	06500	RESPIRATORY THERAPY	399,135	4,265,614	0.093570	1,169,765	109,455	65.00
66.00	06600	PHYSICAL THERAPY	685,022	11,380,365	0.060193	854,029	51,407	66.00
67.00	06700	OCCUPATIONAL THERAPY	65,443	1,705,294	0.038376	424,462	16,289	67.00
68.00	06800	SPEECH PATHOLOGY	92,957	1,811,458	0.051316	188,776	9,687	68.00
69.00	06900	ELECTROCARDIOLOGY	195,900	13,943,642	0.014049	1,291,172	18,140	69.00
69.01	06901	CARDIAC REHAB	179,132	1,842,422	0.097226	10,146	986	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	103,309	837,675	0.123328	79,273	9,777	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	50,388	13,296,077	0.003790	3,714,593	14,078	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	376,118	27,751,354	0.013553	4,292,293	58,173	73.00
73.01	07301	ULTRA SOUND	32,478	11,748,961	0.002764	633,402	1,751	73.01
74.00	07400	RENAL DIALYSIS	1,705	255,232	0.006680	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	666,371	38,121,848	0.017480	0	0	90.00
91.00	09100	EMERGENCY	1,089,897	76,982,016	0.014158	7,318,022	103,609	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	640,139	3,789,273	0.168935	0	0	92.00
200.00		Total (lines 50-199)	10,498,607	493,340,364		41,637,585	932,171	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-0005		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part III Date/Time Prepared: 5/30/2017 11:29 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	PPS Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,449	0.00	6,382	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,856	0.00	855	0		31.00
43.00	04300	NURSERY	3,129	0.00	0	0		43.00
200.00		Total (lines 30-199)	24,434		7,237	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/30/2017 11:29 am
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Cost Center Description			Title XVIII				Hospital	
			Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	PPS
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
50.01	05001	ENDOSCOPY	0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
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	RADIATION-ONCOLOGY	0	0	0	0	0	54.01
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	56.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ULTRA SOUND	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/30/2017 11:29 am
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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	43,856,090	0.000000	0.000000	7,206,950	50.00
50.01	05001	ENDOSCOPY	0	12,589,375	0.000000	0.000000	0	50.01
51.00	05100	RECOVERY ROOM	0	10,503,567	0.000000	0.000000	1,190,368	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	10,829,159	0.000000	0.000000	13,170	52.00
53.00	05300	ANESTHESIOLOGY	0	9,934,065	0.000000	0.000000	1,501,310	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,069,564	0.000000	0.000000	3,747,326	54.00
54.01	05401	RADIATION-ONCOLOGY	0	57,982,856	0.000000	0.000000	169,228	54.01
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	5,197,311	0.000000	0.000000	253,056	56.00
59.00	05900	CARDIAC CATHETERIZATION	0	16,948,983	0.000000	0.000000	2,421,516	59.00
60.00	06000	LABORATORY	0	56,245,746	0.000000	0.000000	5,038,874	60.00
64.00	06400	INTRAVENOUS THERAPY	0	7,452,417	0.000000	0.000000	119,854	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,265,614	0.000000	0.000000	1,169,765	65.00
66.00	06600	PHYSICAL THERAPY	0	11,380,365	0.000000	0.000000	854,029	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,705,294	0.000000	0.000000	424,462	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,811,458	0.000000	0.000000	188,776	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,943,642	0.000000	0.000000	1,291,172	69.00
69.01	06901	CARDIAC REHAB	0	1,842,422	0.000000	0.000000	10,146	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	837,675	0.000000	0.000000	79,273	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	13,296,077	0.000000	0.000000	3,714,593	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	27,751,354	0.000000	0.000000	4,292,293	73.00
73.01	07301	ULTRA SOUND	0	11,748,961	0.000000	0.000000	633,402	73.01
74.00	07400	RENAL DIALYSIS	0	255,232	0.000000	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	38,121,848	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	76,982,016	0.000000	0.000000	7,318,022	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,789,273	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	493,340,364			41,637,585	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/30/2017 11:29 am
Title XVIII		Hospital	PPS

Cost Center Description			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	18,088,277	0	50.00
50.01	05001	ENDOSCOPY	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	944,222	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	696,972	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,041,386	0	54.00
54.01	05401	RADIATION-ONCOLOGY	0	17,718,851	0	54.01
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	1,399,331	0	56.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,348,959	0	59.00
60.00	06000	LABORATORY	0	3,740,841	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	3,283,261	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	420,108	0	65.00
66.00	06600	PHYSICAL THERAPY	0	308,999	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	15,462	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	26,972	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,876,646	0	69.00
69.01	06901	CARDIAC REHAB	0	807,464	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	508,892	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,433,073	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,046,926	0	73.00
73.01	07301	ULTRA SOUND	0	1,904,957	0	73.01
74.00	07400	RENAL DIALYSIS	0	6,172	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	12,207,988	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	704,671	0	92.00
200.00		Total (lines 50-199)	0	84,530,430	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/30/2017 11:29 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.328929	18,088,277	0	0	5,949,759	
50.01 05001 ENDOSCOPY	0.186726	0	0	0	0	
51.00 05100 RECOVERY ROOM	0.436969	944,222	0	0	412,596	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.299124	0	0	0	0	
53.00 05300 ANESTHESIOLOGY	0.159863	696,972	0	0	111,420	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.212065	11,041,386	0	634	2,341,492	
54.01 05401 RADIATION-ONCOLOGY	0.331029	17,718,851	0	13,644	5,865,454	
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.099978	1,399,331	0	0	139,902	
59.00 05900 CARDIAC CATHETERIZATION	0.109809	3,348,959	0	0	367,746	
60.00 06000 LABORATORY	0.190476	3,740,841	1,015	0	712,540	
64.00 06400 INTRAVENOUS THERAPY	0.233806	3,283,261	0	0	767,646	
65.00 06500 RESPIRATORY THERAPY	0.958674	420,108	0	0	402,747	
66.00 06600 PHYSICAL THERAPY	0.736952	308,999	0	0	227,717	
67.00 06700 OCCUPATIONAL THERAPY	0.415423	15,462	0	0	6,423	
68.00 06800 SPEECH PATHOLOGY	0.376850	26,972	0	0	10,164	
69.00 06900 ELECTROCARDIOLOGY	0.126027	1,876,646	0	0	236,508	
69.01 06901 CARDIAC REHAB	0.569816	807,464	0	0	460,106	
70.00 07000 ELECTROENCEPHALOGRAPHY	0.502017	508,892	0	0	255,472	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.594953	1,433,073	0	0	852,611	
73.00 07300 DRUGS CHARGED TO PATIENTS	0.659280	4,046,926	0	5,375	2,668,057	
73.01 07301 ULTRA SOUND	0.074531	1,904,957	0	0	141,978	
74.00 07400 RENAL DIALYSIS	0.762698	6,172	0	0	4,707	
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.207658	0	0	0	0	
91.00 09100 EMERGENCY	0.136062	12,207,988	0	0	1,661,043	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.304625	704,671	0	0	919,331	
200.00		Subtotal (see instructions)	84,530,430	1,015	19,653	24,515,419
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0	0	
202.00		Net Charges (line 200 +/- line 201)	84,530,430	1,015	19,653	24,515,419

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/30/2017 11:29 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
50.01 05001 ENDOSCOPY	0	0		50.01
51.00 05100 RECOVERY ROOM	0	0		51.00
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	134		54.00
54.01 05401 RADIATION-ONCOLOGY	0	4,517		54.01
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0		56.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	193	0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
69.01 06901 CARDIAC REHAB	0	0		69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3,544		73.00
73.01 07301 ULTRA SOUND	0	0		73.01
74.00 07400 RENAL DIALYSIS	0	0		74.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Subtotal (see instructions)	193	8,195		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	193	8,195		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/30/2017 11:29 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		19,449	1.00
2.00	Total swing-bed SNF type inpatient days (including private room days, excluding swing-bed and newborn days)		19,449	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)		16,013	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)		6,382	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		27,982,477	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)		27,982,477	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		27,982,477	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,438.76	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		9,182,166	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)		9,182,166	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/30/2017 11:29 am	
Title XVIII			Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	4,489,741	1,856	2,419.04	855	2,068,279	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					13,553,696	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					24,804,141	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)					1,401,802	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					932,171	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					2,333,973	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					22,470,168	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)					3,436	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,438.76	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					4,943,579	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0005		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/30/2017 11:29 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,623,427	27,982,477	0.129489	4,943,579	640,139	90.00
91.00	Nursing School cost	0	27,982,477	0.000000	4,943,579	0	91.00
92.00	Allied health cost	0	27,982,477	0.000000	4,943,579	0	92.00
93.00	All other Medical Education	0	27,982,477	0.000000	4,943,579	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/30/2017 11:29 am
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		19,449	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		19,449	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)		16,013	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)		569	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)		3,129	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		27,982,477	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)		27,982,477	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		27,982,477	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,438.76	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		818,654	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)		818,654	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/30/2017 11:29 am
Title XIX			Hospital		Cost
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)	1,516,542	3,129	484.67	0	42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	4,489,741	1,856	2,419.04	0	43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					638,772 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,457,426 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)					0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 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)					3,436 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,438.76 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					4,943,579 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0005		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/30/2017 11:29 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,623,427	27,982,477	0.129489	4,943,579	640,139	90.00
91.00	Nursing School cost	0	27,982,477	0.000000	4,943,579	0	91.00
92.00	Allied health cost	0	27,982,477	0.000000	4,943,579	0	92.00
93.00	All other Medical Education	0	27,982,477	0.000000	4,943,579	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/30/2017 11:29 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		7,021,626	30.00
31.00	03100	INTENSIVE CARE UNIT		2,413,622	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.328929	7,206,950	50.00
50.01	05001	ENDOSCOPY	0.186726	0	50.01
51.00	05100	RECOVERY ROOM	0.436969	1,190,368	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.299124	13,170	52.00
53.00	05300	ANESTHESIOLOGY	0.159863	1,501,310	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.212065	3,747,326	54.00
54.01	05401	RADIATION-ONCOLOGY	0.331029	169,228	54.01
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.099978	253,056	56.00
59.00	05900	CARDIAC CATHETERIZATION	0.109809	2,421,516	59.00
60.00	06000	LABORATORY	0.190476	5,038,874	60.00
64.00	06400	INTRAVENOUS THERAPY	0.233806	119,854	64.00
65.00	06500	RESPIRATORY THERAPY	0.958674	1,169,765	65.00
66.00	06600	PHYSICAL THERAPY	0.736952	854,029	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.415423	424,462	67.00
68.00	06800	SPEECH PATHOLOGY	0.376850	188,776	68.00
69.00	06900	ELECTROCARDIOLOGY	0.126027	1,291,172	69.00
69.01	06901	CARDIAC REHAB	0.569816	10,146	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.502017	79,273	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.594953	3,714,593	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.659280	4,292,293	73.00
73.01	07301	ULTRA SOUND	0.074531	633,402	73.01
74.00	07400	RENAL DIALYSIS	0.762698	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.207658	0	90.00
91.00	09100	EMERGENCY	0.136062	7,318,022	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.304625	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		41,637,585	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)		41,637,585	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/30/2017 11:29 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		500,591	30.00
31.00	03100	INTENSIVE CARE UNIT		77,206	31.00
43.00	04300	NURSERY		271,268	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.328929	204,995	50.00
50.01	05001	ENDOSCOPY	0.186726	6,260	50.01
51.00	05100	RECOVERY ROOM	0.436969	33,940	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.299124	680,844	52.00
53.00	05300	ANESTHESIOLOGY	0.159863	52,639	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.212065	132,818	54.00
54.01	05401	RADIATION-ONCOLOGY	0.331029	698	54.01
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.099978	5,036	56.00
59.00	05900	CARDIAC CATHETERIZATION	0.109809	0	59.00
60.00	06000	LABORATORY	0.190476	346,547	60.00
64.00	06400	INTRAVENOUS THERAPY	0.233806	3,520	64.00
65.00	06500	RESPIRATORY THERAPY	0.958674	57,734	65.00
66.00	06600	PHYSICAL THERAPY	0.736952	11,808	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.415423	6,551	67.00
68.00	06800	SPEECH PATHOLOGY	0.376850	3,769	68.00
69.00	06900	ELECTROCARDIOLOGY	0.126027	108,226	69.00
69.01	06901	CARDIAC REHAB	0.569816	433	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.502017	1,538	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.594953	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.659280	188,674	73.00
73.01	07301	ULTRA SOUND	0.074531	36,358	73.01
74.00	07400	RENAL DIALYSIS	0.762698	4,814	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.207658	0	90.00
91.00	09100	EMERGENCY	0.136062	249,293	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.304625	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		2,136,495	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)		2,136,495	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/30/2017 11:29 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		15,913,743	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)		323,821	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)		117.61	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.29	30.00
31.00	Percentage of Medicaid patient days (see instructions)		17.40	31.00
32.00	Sum of lines 30 and 31		19.69	32.00
33.00	Allowable disproportionate share percentage (see instructions)		5.55	33.00
34.00	Disproportionate share adjustment (see instructions)		220,803	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/30/2017 11:29 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000094924	0.000092300	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	608,096	551,724	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	455,241	139,065	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	594,306		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 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)	17,052,673		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		17,052,673	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,388,474	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see 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)		18,441,147	59.00
60.00	Primary payer payments		6,911	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		18,434,236	61.00
62.00	Deductibles billed to program beneficiaries		1,940,093	62.00
63.00	Coinurance billed to program beneficiaries		8,694	63.00
64.00	Allowable bad debts (see instructions)		129,943	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		84,463	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		15,156	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		16,569,912	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)		80,671	70.93
70.94	HRR adjustment amount (see instructions)		-28,611	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/30/2017 11:29 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	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	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)			16,621,972	71.00
71.01	Sequestration adjustment (see instructions)			332,439	71.01
72.00	Interim payments			16,279,384	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)			10,149	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			344,327	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0005

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/30/2017 11:29 am

		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	0	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	15,913,743	0	0	15,913,743	15,913,743	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	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	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	323,821	0	0	323,821	323,821	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0.000000	5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	0.000000	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0555	0.0555	0.0555	0.0555	0.0555	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	220,803	0	0	220,803	220,803	11.00
11.01	Uncompensated care payments	36.00	594,306	0	455,241	139,065	594,306	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	17,052,673	0	455,241	16,597,432	17,052,673	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	17,052,673	0	455,241	16,597,432	17,052,673	15.00
16.00	Payment for inpatient program capital	50.00	1,388,474	0	0	1,388,474	1,388,474	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0005

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/30/2017 11:29 am

		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	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	455,241	17,985,906	18,441,147	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	1,279,423	0	0	1,279,423	1,279,423	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	56,978	0	0	56,978	56,978	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	0.0407	0.0407	0.0407	0.0407		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	52,073	0	0	52,073	52,073	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,388,474	0	0	1,388,474	1,388,474	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: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2017 11:29 am
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		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 (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	15,913,743		15,913,743	15,913,743	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	323,821	0	323,821	323,821	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0555	0.0555	0.0555		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	220,803	0	220,803	220,803	11.00
11.01	Uncompensated care payments	36.00	594,306	455,241	139,065	594,306	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	17,052,673	455,241	16,597,432	17,052,673	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	17,052,673	455,241	16,597,432	17,052,673	15.00
16.00	Payment for inpatient program capital	50.00	1,388,474	0	1,388,474	1,388,474	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			455,241	17,985,906	18,441,147	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 15-0005		Period: From 01/01/2016 To 12/31/2016		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/30/2017 11:29 am	
		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	1,279,423	0	1,279,423	1,279,423	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	56,978	0	56,978	56,978	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	0.0407	0.0407	0.0407		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	52,073	0	52,073	52,073	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,388,474	0	1,388,474	1,388,474	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	80,671	0	80,671	80,671	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	-28,611	0	-28,611	-28,611	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/30/2017 11:29 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		8,388	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		24,515,419	2.00
3.00	PPS payments		15,079,133	3.00
4.00	Outlier payment (see instructions)		474,885	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)		8,388	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		20,668	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)		20,668	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)		20,668	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		12,280	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)		8,388	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)		15,554,018	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		3,099,514	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)		12,462,892	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)		12,462,892	30.00
31.00	Primary payer payments		2,848	31.00
32.00	Subtotal (line 30 minus line 31)		12,460,044	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		187,828	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		122,088	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		57,828	36.00
37.00	Subtotal (see instructions)		12,582,132	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-250	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)		12,582,382	40.00
40.01	Sequestration adjustment (see instructions)		251,648	40.01
41.00	Interim payments		12,449,029	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-118,295	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0005		Period: From 01/01/2016 To 12/31/2016		Worksheet E-1 Part I Date/Time Prepared: 5/30/2017 11:29 am	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		16,126,090		12,203,594	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	12/31/2016	98,394	12/31/2016	245,435	3.01	
3.02		07/08/2016	54,900		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)		153,294		245,435	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)		16,279,384		12,449,029	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		10,149		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		118,295	6.02	
7.00	Total Medicare program liability (see instructions)		16,289,533		12,330,734	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		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2017 11:29 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		1,457,426		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)		1,457,426	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)		1,457,426	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		849,065		8.00
9.00	Ancillary service charges		2,136,495	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)		2,985,560	0	12.00
CUSTOMARY CHARGES					
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)		2,985,560	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		1,528,134	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)		1,457,426	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
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)		1,457,426	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
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)		1,457,426	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		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)		1,457,426	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		1,457,426	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)		1,457,426	0	40.00
41.00	Interim payments		1,304,749	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		152,677	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: 15-0005

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

Worksheet G

Date/Time Prepared:
5/30/2017 11:29 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	5,672,854	0	0	0	1.00
2.00	Temporary investments	95,263	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	84,850,179	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-53,554,457	0	0	0	6.00
7.00	Inventory	2,159,737	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	39,854,574	0	0	0	9.00
10.00	Due from other funds	6,122,079	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	85,200,229	0	0	0	11.00
FIXED ASSETS						
12.00	Land	20,928,211	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	12,830,797	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	352,993,470	0	0	0	19.00
20.00	Accumulated depreciation	-171,029,644	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	215,722,834	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	222,575,137	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	18,275,663	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	240,850,800	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	541,773,863	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	8,559,085	0	0	0	37.00
38.00	Salaries, wages, and fees payable	10,936,758	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	1,446,386	0	0	0	43.00
44.00	Other current liabilities	43,244,815	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	64,187,044	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	112,845,969	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	112,845,969	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	177,033,013	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	364,740,850				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)	364,740,850	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	541,773,863	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0005

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

Worksheet G-1

Date/Time Prepared:
5/30/2017 11:29 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		348,536,968		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		16,203,882				2.00
3.00	Total (sum of line 1 and line 2)		364,740,850		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		364,740,850		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		364,740,850		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	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0005

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/30/2017 11:29 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	27,659,521		27,659,521	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	27,659,521		27,659,521	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,318,363		5,318,363	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)	5,318,363		5,318,363	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	32,977,884		32,977,884	17.00
18.00	Ancillary services	90,661,427	283,785,799	374,447,226	18.00
19.00	Outpatient services	14,007,558	104,885,578	118,893,136	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	PRIMARY CARE CLINIC	0	226,137	226,137	27.00
27.01	OCCUPATIONAL MEDICINE	0	1,009,660	1,009,660	27.01
27.02	SCHOOL AND TOWN CLINICS	0	1,462,944	1,462,944	27.02
27.03	PROFESSIONAL FEES	12,088,663	61,994,426	74,083,089	27.03
27.04	LAB DISCOUNT	0	-589,875	-589,875	27.04
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	149,735,532	452,774,669	602,510,201	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		256,107,383		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)		256,107,383		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0005

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

Worksheet G-3

Date/Time Prepared:
5/30/2017 11:29 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	602,510,201	1.00
2.00	Less contractual allowances and discounts on patients' accounts	350,079,487	2.00
3.00	Net patient revenues (line 1 minus line 2)	252,430,714	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	256,107,383	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,676,669	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	12,614,860	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	15,379	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	7,250,312	24.00
25.00	Total other income (sum of lines 6-24)	19,880,551	25.00
26.00	Total (line 5 plus line 25)	16,203,882	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	16,203,882	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0005	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 5/30/2017 11:29 am
		Title XVII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,279,423	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		56,978	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)		50.08	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)		2.29	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		17.40	8.00
9.00	Sum of lines 7 and 8		19.69	9.00
10.00	Allowable disproportionate share percentage (see instructions)		4.07	10.00
11.00	Disproportionate share adjustment (see instructions)		52,073	11.00
12.00	Total prospective capital payments (see instructions)		1,388,474	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00