

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: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/31/2017 3:58 pm
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PART I - COST REPORT STATUS

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

Contractor use only
 5. Cost Report Status
 (1) As Submitted
 (2) Settled without Audit
 (3) Settled with Audit
 (4) Reopened
 (5) Amended

6. Date Received:
 7. Contractor No.
 8. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN

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

Date: 5/31/2017 Time: 3:58 pm

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by KATHERINE SHAW BETHEA (14-0012) 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	200,894	41,906	262,924	0	1.00
2.00 Subprovider - IPF	0	32	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
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	200,926	41,906	262,924	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0012		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 5/31/2017 3:55 pm				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: KATHERINE SHAW BETHEA HOSPITAL			PO Box: 403 EAST							1.00	
2.00	City: DIXON			State: IL		Zip Code: 61021		County: LEE			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	9.00		
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		KATHERINE SHAW BETHEA		140012	99914	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF		KSB PSYCH		14S012	99914	4	11/01/1983	N	P	O	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		KSB HOME HEALTH		147131	99914		07/07/1976	N	P	N	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.						1	N		23.00		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			1,146	1,324	0	0	0	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: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/31/2017 3:55 pm			
		Urban/Rural S	Date of Geogr				
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2			26.00		
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2			27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00		
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00		
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0			37.00		
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N			37.01		
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.				38.00		
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	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	Y		40.00		
		V	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)	N	N	N	45.00		
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00		
47.00	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00		
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00		
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y			56.00		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00		
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00		
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

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	Y/N	IME	Direct GME	IME	Direct GME					
	1.00	2.00	3.00	4.00	5.00					
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)							61.06		
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count					
	1.00	2.00	3.00	4.00						
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.						0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.						0.00	0.00	61.20	
						1.00				
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)									
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)						0.00	62.01		
Teaching Hospitals that Claim Residents in Nonprovider Settings										
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)						N	63.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))					
			1.00	2.00	3.00					
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.									
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))				
		1.00	2.00	3.00	4.00	5.00				
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						0.00	0.00	0.000000	65.00

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
		1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 67.00	
				1.00	2.00	3.00	
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.			Y		70.00	
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	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)					0	76.00
				1.00			
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				N	81.00	
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00	
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.				N	87.00	
				V	XIX		
				1.00	2.00		
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00	

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		V		XIX			
		1.00		2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00	
Rural Providers							
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N				105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	N				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical		Speech		Respiratory	
		1.00		3.00		4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N		N		109.00	
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N		110.00	
						1.00 2.00 3.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0	
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:	448,755		1,051,088		0	
						1.00 2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00	
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: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/31/2017 3:55 pm			
		1.00	2.00				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		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.		N		N	145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N			146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital		N			N	
156.00	Subprovider - IPF		N			N	
157.00	Subprovider - IRF		N			N	
158.00	SUBPROVIDER						
159.00	SNF		N			N	
160.00	HOME HEALTH AGENCY		N			N	
161.00	CMHC					N	
				1.00			
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.25	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 5/31/2017 3:55 pm
		Beginning 1.00	Ending 2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2015	09/30/2016	170.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0012		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part II Date/Time Prepared: 5/31/2017 3:55 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/22/2017			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.	Y					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	Y					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	02/28/2017	Y	02/28/2017		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: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/31/2017 3:55 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	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				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00		2.00	
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.	KEVIN		WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446		KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 5/31/2017 3:55 pm
		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, REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0012

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

Worksheet S-3
Part I
Date/Time Prepared:
5/31/2017 3:55 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	60	21,960	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)		60	21,960	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,196	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		66	24,156	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	14	5,124		0	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	46.00	0	0			21.00
22.00 HOME HEALTH AGENCY	101.00				0	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)		80				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: 14-0012

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

Worksheet S-3
Part I
Date/Time Prepared:
5/31/2017 3:55 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,640	1,666	7,415			1.00
2.00 HMO and other (see instructions)	0	0				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)	3,640	1,666	7,415			7.00
8.00 INTENSIVE CARE UNIT	179	478	1,061			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		326	616			13.00
14.00 Total (see instructions)	3,819	2,470	9,092	3.63	716.70	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	784	1,672	2,692	0.00	20.37	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			0	0.00	0.00	21.00
22.00 HOME HEALTH AGENCY	2,527	478	6,574	0.00	8.91	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)				3.63	745.98	27.00
28.00 Observation Bed Days		481	2,537			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	0	82			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: 14-0012

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

Worksheet S-3
Part I
Date/Time Prepared:
5/31/2017 3:55 pm

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	1,133	642	2,929	1.00	
2.00 HMO and other (see instructions)			0	0		2.00	
3.00 HMO IPF Subprovider				0		3.00	
4.00 HMO IRF Subprovider				0		4.00	
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00	
6.00 Hospital Adults & Peds. Swing Bed NF						6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00	
8.00 INTENSIVE CARE UNIT						8.00	
9.00 CORONARY CARE UNIT						9.00	
10.00 BURN INTENSIVE CARE UNIT						10.00	
11.00 SURGICAL INTENSIVE CARE UNIT						11.00	
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00	
13.00 NURSERY						13.00	
14.00 Total (see instructions)	0.00	0	1,133	642	2,929	14.00	
15.00 CAH visits						15.00	
16.00 SUBPROVIDER - IPF	0.00	0	139	263	559	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	0.00				0	21.00	
22.00 HOME HEALTH AGENCY	0.00					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: 14-0012		Period: From 01/01/2016 To 12/31/2016		Worksheet S-3 Part II Date/Time Prepared: 5/31/2017 3:55 pm	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	59,493,971	0	59,493,971	1,557,608.00	38.20	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		1,469,296	0	1,469,296	6,321.00	232.45	4.00
4.01	Physicians - Part A - Teaching		129,421	0	129,421	1,482.00	87.33	4.01
5.00	Physician and Non-Physician-Part B		20,369,573	0	20,369,573	113,587.00	179.33	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	250,795	0	250,795	11,314.00	22.17	7.00
7.01	Contracted interns and residents (in an approved programs)		573,737	0	573,737	16,704.00	34.35	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)		1,634,132	-124,631	1,509,501	61,272.00	24.64	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract Labor: Direct Patient Care		864,519	0	864,519	21,451.00	40.30	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		34,660	0	34,660	149.00	232.62	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)		15,519,176	0	15,519,176			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		697,322	0	697,322			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		71,938	0	71,938			22.00
22.01	Physician Part A - Teaching		16,866	0	16,866			22.01
23.00	Physician Part B		1,292,702	0	1,292,702			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		128,761	0	128,761			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
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	1,693,360	0	1,693,360	18,496.00	91.55	26.00
27.00	Administrative & General	5.00	6,221,310	-387,321	5,833,989	202,109.00	28.87	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0012

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

Worksheet S-3
Part II
Date/Time Prepared:
5/31/2017 3:55 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	800,020	12,927	812,947	36,872.00	22.05
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	31.00
32.00	Housekeeping	9.00	753,128	-174,685	578,443	53,069.00	10.90
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	33.00
34.00	Dietary	10.00	979,770	-286,558	693,212	46,531.00	14.90
35.00	Dietary under contract (see instructions)		0	0	0	0.00	35.00
36.00	Cafeteria	11.00	0	286,558	286,558	19,235.00	14.90
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	37.00
38.00	Nursing Administration	13.00	1,291,702	-191,637	1,100,065	30,806.00	35.71
39.00	Central Services and Supply	14.00	0	0	0	0.00	39.00
40.00	Pharmacy	15.00	771,764	0	771,764	20,715.00	37.26
41.00	Medical Records & Medical Records Library	16.00	885,143	-6,530	878,613	15,149.00	58.00
42.00	Social Service	17.00	0	230,970	230,970	8,549.00	27.02
43.00	Other General Service	18.00	0	0	0	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0012

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

Worksheet S-3
Part III
Date/Time Prepared:
5/31/2017 3:55 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	38,170,445	0	38,170,445	1,414,521.00	26.98	1.00
2.00	Excluded area salaries (see instructions)	1,634,132	-124,631	1,509,501	61,272.00	24.64	2.00
3.00	Subtotal salaries (line 1 minus line 2)	36,536,313	124,631	36,660,944	1,353,249.00	27.09	3.00
4.00	Subtotal other wages & related costs (see inst.)	899,179	0	899,179	21,600.00	41.63	4.00
5.00	Subtotal wage-related costs (see inst.)	15,591,114	0	15,591,114	0.00	42.53	5.00
6.00	Total (sum of lines 3 thru 5)	53,026,606	124,631	53,151,237	1,374,849.00	38.66	6.00
7.00	Total overhead cost (see instructions)	13,396,197	-516,276	12,879,921	451,531.00	28.52	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part IV Date/Time Prepared: 5/31/2017 3:55 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			2,750,810 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			203,539 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			15,688 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)			7,997,744 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			1,773,299 9.00
10.00	Dental, Hearing and Vision Plan			456,249 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			71,209 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)			394,774 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			290,731 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			3,261,994 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			94,496 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))			149,615 21.00
22.00	Day Care Cost and Allowances			72,499 22.00
23.00	Tuition Reimbursement			162,399 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			17,695,046 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: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part V Date/Time Prepared: 5/31/2017 3:55 pm
Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	864,519	17,695,046	1.00
2.00	Hospital	864,519	17,695,046	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC	0	0	10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC	0	0	12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC	0	0	16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-0012 Component CCN: 14-7131		Period: From 01/01/2016 To 12/31/2016		Worksheet S-4 Date/Time Prepared: 5/31/2017 3:55 pm	
				Home Health Agency I		PPS	
				1.00			
0.00	County			LEE		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	1,030	0	550	1,580	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	206.00	36.00	228.00	470.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.76	0.00	1.76	4.00
5.00	Other Administrative Personnel			1.75	0.00	1.75	5.00
6.00	Direct Nursing Service			5.46	0.00	5.46	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.89	0.00	0.89	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914			20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	955	46	60	6	1,067	21.00
22.00	Skilled Nursing Visit Charges	308,160	14,720	19,520	1,920	344,320	22.00
23.00	Physical Therapy Visits	1,118	0	30	0	1,148	23.00
24.00	Physical Therapy Visit Charges	444,640	0	11,910	0	456,550	24.00
25.00	Occupational Therapy Visits	92	0	5	0	97	25.00
26.00	Occupational Therapy Visit Charges	38,088	0	2,070	0	40,158	26.00
27.00	Speech Pathology Visits	17	0	0	0	17	27.00
28.00	Speech Pathology Visit Charges	5,440	0	0	0	5,440	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	184	13	1	0	198	31.00
32.00	Home Health Aide Visit Charges	27,416	1,937	149	0	29,502	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,366	59	96	6	2,527	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	823,744	16,657	33,649	1,920	875,970	35.00
36.00	Total Number of Episodes (standard/non outlier)	181		37	1	219	36.00
37.00	Total Number of Outlier Episodes		2		0	2	37.00
38.00	Total Non-Routine Medical Supply Charges	62,707	18,970	5,068	0	86,745	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet S-10 Date/Time Prepared: 5/31/2017 3:55 pm
				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)		0.232381	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		19,085,986	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		65,533,098	6.00
7.00	Medicaid cost (line 1 times line 6)		15,228,647	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)		0	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		66,319	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	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)	0	4,269,737	4,269,737
21.00	Cost of patients approved for charity care (line 1 times line 20)	0	992,206	992,206
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	0	992,206	992,206
				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)		6,381,119	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		198,298	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		6,182,821	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,436,770	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,428,976	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,428,976	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0012

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

Worksheet A
Date/Time Prepared:
5/31/2017 3:55 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		5,486,672	5,486,672	-933,685	4,552,987	1.00
2.00	00200		0	0	1,606,894	1,606,894	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	1,693,360	14,502,736	16,196,096	0	16,196,096	4.00
5.01	00540	0	0	0	475,085	475,085	5.01
5.02	00590	797,087	4,040,749	4,837,836	-473,962	4,363,874	5.02
5.03	00591	334,695	805,355	1,140,050	14,174	1,154,224	5.03
5.04	00580	1,860,114	2,021,746	3,881,860	-1,546,626	2,335,234	5.04
5.05	00592	3,229,414	7,003,652	10,233,066	-25,066	10,208,000	5.05
7.00	00700	800,020	2,488,368	3,288,388	-173,259	3,115,129	7.00
8.00	00800	0	284,711	284,711	0	284,711	8.00
9.00	00900	753,128	498,184	1,251,312	-188,048	1,063,264	9.00
10.00	01000	979,770	651,736	1,631,506	-854,409	777,097	10.00
11.00	01100	0	0	0	854,409	854,409	11.00
13.00	01300	1,291,702	439,148	1,730,850	-206,297	1,524,553	13.00
14.00	01400	0	3,438,887	3,438,887	-3,423,200	15,687	14.00
15.00	01500	771,764	2,002,342	2,774,106	-1,324,106	1,450,000	15.00
16.00	01600	885,143	2,658,532	3,543,675	-12,701	3,530,974	16.00
17.00	01700	0	0	0	72,091	72,091	17.00
17.01	01701	0	0	0	176,310	176,310	17.01
21.00	02100	250,795	0	250,795	602,235	853,030	21.00
22.00	02200	946,356	814,777	1,761,133	-472,814	1,288,319	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,424,566	586,438	4,011,004	25,301	4,036,305	30.00
31.00	03100	1,112,927	306,805	1,419,732	2,529	1,422,261	31.00
40.00	04000	1,034,360	330,114	1,364,474	404	1,364,878	40.00
43.00	04300	366,754	62,640	429,394	2,165	431,559	43.00
46.00	04600	124,631	7,143	131,774	-131,774	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,760,451	1,138,389	2,898,840	-116,384	2,782,456	50.00
52.00	05200	0	0	0	107,446	107,446	52.00
53.00	05300	926,806	102,434	1,029,240	12,302	1,041,542	53.00
53.01	03950	0	46,682	46,682	-46,682	0	53.01
54.00	05400	1,345,355	1,100,977	2,446,332	3,116	2,449,448	54.00
54.01	05401	373,397	149,994	523,391	1,016	524,407	54.01
57.00	05700	122,416	227,720	350,136	0	350,136	57.00
58.00	05800	179,015	184,554	363,569	-17	363,552	58.00
59.00	05900	0	0	0	457,016	457,016	59.00
60.00	06000	2,326,954	2,750,225	5,077,179	4,034	5,081,213	60.00
65.00	06500	753,072	229,484	982,556	-170,288	812,268	65.00
66.00	06600	1,433,573	385,448	1,819,021	-84,451	1,734,570	66.00
67.00	06700	259,153	102,144	361,297	45,662	406,959	67.00
68.00	06800	289,548	131,285	420,833	-84,140	336,693	68.00
69.00	06900	964,541	2,366,951	3,331,492	-1,963,282	1,368,210	69.00
70.00	07000	212,927	40,369	253,296	611	253,907	70.00
71.00	07100	0	0	0	496,011	496,011	71.00
71.01	07101	292,124	23,522	315,646	0	315,646	71.01
72.00	07200	0	0	0	5,088,008	5,088,008	72.00
73.00	07300	0	745,062	745,062	1,345,594	2,090,656	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	22,730,200	2,978,022	25,708,222	1,539,578	27,247,800	90.01
91.00	09100	4,392,712	714,489	5,107,201	-9,697	5,097,504	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	475,141	110,175	585,316	-7,187	578,129	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		683,916	683,916	-683,916	0	113.00
118.00		59,493,971	62,642,577	122,136,548	0	122,136,548	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	1,099,521	1,099,521	0	1,099,521	194.01
194.02	07952	0	0	0	0	0	194.02
200.00		59,493,971	63,742,098	123,236,069	0	123,236,069	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0012

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

Worksheet A
Date/Time Prepared:
5/31/2017 3:55 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-122,895	4,430,092	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-20,810	1,586,084	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-25,900	16,170,196	4.00
5.01	00540	NONPATIENT TELEPHONES	0	475,085	5.01
5.02	00590	DATA PROCESSING	0	4,363,874	5.02
5.03	00591	PURCHASING RECEIVING AND STORES	-28,645	1,125,579	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	-17,354	2,317,880	5.04
5.05	00592	OTHER ADMIN & GENERAL	-3,555,832	6,652,168	5.05
7.00	00700	OPERATION OF PLANT	-372,634	2,742,495	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	284,711	8.00
9.00	00900	HOUSEKEEPING	0	1,063,264	9.00
10.00	01000	DIETARY	-886	776,211	10.00
11.00	01100	CAFETERIA	-412,011	442,398	11.00
13.00	01300	NURSING ADMINISTRATION	-206,851	1,317,702	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	15,687	14.00
15.00	01500	PHARMACY	0	1,450,000	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-128,544	3,402,430	16.00
17.00	01700	SOCIAL SERVICE	0	72,091	17.00
17.01	01701	UTILIZATION REVIEW	-3,117	173,193	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	853,030	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	1,288,319	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	4,036,305	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,422,261	31.00
40.00	04000	SUBPROVIDER - IPF	-225,376	1,139,502	40.00
43.00	04300	NURSERY	0	431,559	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,782,456	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	107,446	52.00
53.00	05300	ANESTHESIOLOGY	-926,806	114,736	53.00
53.01	03950	PAIN MANAGEMENT	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,235	2,448,213	54.00
54.01	05401	ULTRASOUND	0	524,407	54.01
57.00	05700	CT SCAN	0	350,136	57.00
58.00	05800	MRI	0	363,552	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	457,016	59.00
60.00	06000	LABORATORY	-497,653	4,583,560	60.00
65.00	06500	RESPIRATORY THERAPY	-1,100	811,168	65.00
66.00	06600	PHYSICAL THERAPY	0	1,734,570	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	406,959	67.00
68.00	06800	SPEECH PATHOLOGY	0	336,693	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,368,210	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	253,907	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	496,011	71.00
71.01	07101	PSYCHIATRY/PSYCHOLOGICAL SERV	-99,645	216,001	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,088,008	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,090,656	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	PROVIDER BASED CLINICS	-17,366,571	9,881,229	90.01
91.00	09100	EMERGENCY	-2,126,520	2,970,984	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	578,129	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-26,140,385	95,996,163	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	190.00
194.00	07950	MEALS ON WHEELS	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	1,099,521	194.01
194.02	07952	IHAP	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-26,140,385	97,095,684	200.00

RECLASSIFICATIONS

Provider CCN: 14-0012

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

Worksheet A-6
Date/Time Prepared:
5/31/2017 3:55 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - DIETARY TO CAFETERIA						
1.00	CAFETERIA	11.00	286,558	567,851	1.00	
	O		286,558	567,851		
B - LABOR & DELIVERY						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	81,948	22,531	1.00	
	O		81,948	22,531		
C - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	512,005	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	86,698	2.00	
3.00	OTHER ADMIN & GENERAL	5.05	0	85,213	3.00	
	O		0	683,916		
D - COMMUNICATIONS EXPENSE						
1.00	NONPATIENT TELEPHONES	5.01	197,353	277,732	1.00	
	O		197,353	277,732		
E - BILLABLE SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	483,415	1.00	
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,088,008	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	
	O		0	5,571,423		
F - BILLABLE DRUGS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,345,594	1.00	
	O		0	1,345,594		
G - TRAVEL EXPENSES TO HHC						
1.00	HOME HEALTH AGENCY	101.00	0	5,384	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
	O		0	5,384		
H - PROPERTY INSURANCE						
1.00	OTHER CAP REL COSTS	3.00	0	98,726	1.00	
2.00		0.00	0	0	2.00	
	O		0	98,726		
I - PT DIRECTOR SALARY TO OT						
1.00	OCCUPATIONAL THERAPY	67.00	44,935	0	1.00	
2.00	SPEECH PATHOLOGY	68.00	14,978	0	2.00	
	O		59,913	0		
J - BIO-MED COSTS						
1.00	OTHER ADMIN & GENERAL	5.05	0	464	1.00	
2.00	PHARMACY	15.00	0	21,488	2.00	
3.00	ADULTS & PEDIATRICS	30.00	0	5,331	3.00	
4.00	INTENSIVE CARE UNIT	31.00	0	5,631	4.00	
5.00	SUBPROVIDER - IPF	40.00	0	411	5.00	
6.00	NURSERY	43.00	0	2,212	6.00	
7.00	OPERATING ROOM	50.00	0	66,232	7.00	
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	2,967	8.00	
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	460	9.00	
10.00	LABORATORY	60.00	0	4,882	10.00	
11.00	RESPIRATORY THERAPY	65.00	0	11,769	11.00	
12.00	PHYSICAL THERAPY	66.00	0	1,572	12.00	
13.00	ELECTROCARDIOLOGY	69.00	0	6,534	13.00	
14.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	12,596	14.00	
15.00	PROVIDER BASED CLINICS	90.01	0	37,771	15.00	
16.00	EMERGENCY	91.00	0	6,855	16.00	
	O		0	187,175		

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
K - HOUSEKEEPING					
1.00	DATA PROCESSING	5.02	1,043	80	1.00
2.00	PURCHASING RECEIVING AND STORES	5.03	13,167	1,007	2.00
3.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	13,946	1,067	3.00
4.00	OTHER ADMIN & GENERAL	5.05	8,473	648	4.00
5.00	OPERATION OF PLANT	7.00	12,927	989	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	3,412	261	6.00
7.00	ULTRASOUND	54.01	1,370	105	7.00
8.00	LABORATORY	60.00	1,686	129	8.00
9.00	PHYSICAL THERAPY	66.00	6,006	459	9.00
10.00	OCCUPATIONAL THERAPY	67.00	6,005	459	10.00
11.00	SPEECH PATHOLOGY	68.00	767	59	11.00
12.00	ELECTROCARDIOLOGY	69.00	4,693	359	12.00
13.00	ELECTROENCEPHALOGRAPHY	70.00	2,196	168	13.00
14.00	PROVIDER BASED CLINICS	90.01	98,994	7,573	14.00
	O		174,685	13,363	
L - UTILIZATION REVIEW					
1.00	UTILIZATION REVIEW	17.01	160,885	12,308	1.00
2.00		0.00	0	0	2.00
	O		160,885	12,308	
M - MEDICAL DIRECTOR					
1.00	UTILIZATION REVIEW	17.01	3,117	0	1.00
	O		3,117	0	
O - PHYSICIAN MEETING TIME					
1.00	MEDICAL RECORDS & LIBRARY	16.00	74,131	0	1.00
2.00		0.00	0	0	2.00
	O		74,131	0	
P - PHYSICIAN PRACTICE AMORTIZATION					
1.00	PROVIDER BASED CLINICS	90.01	0	24,220	1.00
	O		0	24,220	
Q - RESIDENCY COSTS					
1.00	I&R SERVICES-SALARY & FRINGES A	21.00	0	602,235	1.00
2.00	I&R SERVICES-OTHER PRGM COSTS A	22.00	129,421	0	2.00
3.00		0.00	0	0	3.00
	O		129,421	602,235	
R - CODER SALARIES					
1.00	PROVIDER BASED CLINICS	90.01	44,445	3,400	1.00
	O		44,445	3,400	
S - CARDIAC CATH LAB SALARIES					
1.00	CARDIAC CATHETERIZATION	59.00	308,653	148,363	1.00
	O		308,653	148,363	
T - EKG SALARIES					
1.00	ELECTROCARDIOLOGY	69.00	100,148	71,632	1.00
	O		100,148	71,632	
U - BILLER SALARIES					
1.00	PROVIDER BASED CLINICS	90.01	402,812	1,158,827	1.00
	O		402,812	1,158,827	
V - PATIENT ADVOCATE SALARIES					
1.00	SOCIAL SERVICE	17.00	66,968	5,123	1.00
	O		66,968	5,123	
W - MOVEABLE EQUIPMENT					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,490,007	1.00
	O		0	1,490,007	
X - OTHER LTC & PAIN MGMT					
1.00	ADULTS & PEDIATRICS	30.00	124,631	7,143	1.00
2.00	ANESTHESIOLOGY	53.00	0	46,682	2.00
	TOTALS		124,631	53,825	
500.00	Grand Total: Increases		2,215,668	12,343,635	500.00

RECLASSIFICATIONS

Provider CCN: 14-0012

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

Worksheet A-6
Date/Time Prepared:
5/31/2017 3:55 pm

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - DIETARY TO CAFETERIA						
1.00	DIETARY	10.00	286,558	567,851	0	1.00
	O		286,558	567,851		
B - LABOR & DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	81,948	22,531	0	1.00
	O		81,948	22,531		
C - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	683,916	11	1.00
2.00		0.00	0	0	11	2.00
3.00		0.00	0	0	0	3.00
	O		0	683,916		
D - COMMUNICATIONS EXPENSE						
1.00	DATA PROCESSING	5.02	197,353	277,732	0	1.00
	O		197,353	277,732		
E - BILLABLE SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,423,200	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	7,325	0	2.00
3.00	INTENSIVE CARE UNIT	31.00	0	3,102	0	3.00
4.00	SUBPROVIDER - IPF	40.00	0	7	0	4.00
5.00	NURSERY	43.00	0	47	0	5.00
6.00	OPERATING ROOM	50.00	0	182,616	0	6.00
7.00	ANESTHESIOLOGY	53.00	0	34,380	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,017	0	8.00
9.00	ULTRASOUND	54.01	0	459	0	9.00
10.00	MRI	58.00	0	17	0	10.00
11.00	LABORATORY	60.00	0	2,663	0	11.00
12.00	RESPIRATORY THERAPY	65.00	0	10,277	0	12.00
13.00	PHYSICAL THERAPY	66.00	0	28,641	0	13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	4,697	0	14.00
15.00	SPEECH PATHOLOGY	68.00	0	99,534	0	15.00
16.00	ELECTROCARDIOLOGY	69.00	0	1,689,632	0	16.00
17.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,753	0	17.00
18.00	PROVIDER BASED CLINICS	90.01	0	58,270	0	18.00
19.00	EMERGENCY	91.00	0	11,215	0	19.00
20.00	HOME HEALTH AGENCY	101.00	0	12,571	0	20.00
	O		0	5,571,423		
F - BILLABLE DRUGS						
1.00	PHARMACY	15.00	0	1,345,594	0	1.00
	O		0	1,345,594		
G - TRAVEL EXPENSES TO HHC						
1.00	PHYSICAL THERAPY	66.00	0	3,934	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0	1,040	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0	410	0	3.00
	O		0	5,384		
H - PROPERTY INSURANCE						
1.00	OTHER ADMIN & GENERAL	5.05	0	98,726	12	1.00
2.00		0.00	0	0	12	2.00
	O		0	98,726		
I - PT DIRECTOR SALARY TO OT						
1.00	PHYSICAL THERAPY	66.00	59,913	0	0	1.00
2.00		0.00	0	0	0	2.00
	O		59,913	0		
J - BIO-MED COSTS						
1.00	OPERATION OF PLANT	7.00	0	187,175	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
	O		0	187,175		
K - HOUSEKEEPING						
1.00	HOUSEKEEPING	9.00	174,685	13,363	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00

Decreases							
Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
4.00	0.00	0	0	0	0		4.00
5.00	0.00	0	0	0	0		5.00
6.00	0.00	0	0	0	0		6.00
7.00	0.00	0	0	0	0		7.00
8.00	0.00	0	0	0	0		8.00
9.00	0.00	0	0	0	0		9.00
10.00	0.00	0	0	0	0		10.00
11.00	0.00	0	0	0	0		11.00
12.00	0.00	0	0	0	0		12.00
13.00	0.00	0	0	0	0		13.00
14.00	0.00	0	0	0	0		14.00
O		174,685	13,363				
L - UTILIZATION REVIEW							
1.00	MEDICAL RECORDS & LIBRARY	16.00	36,216	2,771	0		1.00
2.00	NURSING ADMINISTRATION	13.00	124,669	9,537	0		2.00
O			160,885	12,308			
M - MEDICAL DIRECTOR							
1.00	PROVIDER BASED CLINICS	90.01	3,117	0	0		1.00
O			3,117	0			
O - PHYSICIAN MEETING TIME							
1.00	PROVIDER BASED CLINICS	90.01	68,794	0	0		1.00
2.00	EMERGENCY	91.00	5,337	0	0		2.00
O			74,131	0			
P - PHYSICIAN PRACTICE AMORTIZATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	24,220	9		1.00
O			0	24,220			
Q - RESIDENCY COSTS							
1.00	I&R SERVICES-OTHER PRGM COSTS A	22.00	0	602,235	0		1.00
2.00	OTHER ADMIN & GENERAL	5.05	21,138	0	0		2.00
3.00	PROVIDER BASED CLINICS	90.01	108,283	0	0		3.00
O			129,421	602,235			
R - CODER SALARIES							
1.00	MEDICAL RECORDS & LIBRARY	16.00	44,445	3,400	0		1.00
O			44,445	3,400			
S - CARDIAC CATH LAB SALARIES							
1.00	ELECTROCARDIOLOGY	69.00	308,653	148,363	0		1.00
O			308,653	148,363			
T - EKG SALARIES							
1.00	RESPIRATORY THERAPY	65.00	100,148	71,632	0		1.00
O			100,148	71,632			
U - BILLER SALARIES							
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	402,812	1,158,827	0		1.00
O			402,812	1,158,827			
V - PATIENT ADVOCATE SALARIES							
1.00	NURSING ADMINISTRATION	13.00	66,968	5,123	0		1.00
O			66,968	5,123			
W - MOVEABLE EQUIPMENT							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,490,007	9		1.00
O			0	1,490,007			
X - OTHER LTC & PAIN MGMT							
1.00	OTHER LONG TERM CARE	46.00	124,631	7,143	0		1.00
2.00	PAIN MANAGEMENT	53.01	0	46,682	0		2.00
	TOTALS		124,631	53,825			
500.00	Grand Total: Decreases		2,215,668	12,343,635			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0012

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

Worksheet A-7
Part I
Date/Time Prepared:
5/31/2017 3:55 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,129,972	0	0	0	1.00
2.00	Land Improvements	5,286,998	106,442	0	106,442	2.00
3.00	Buildings and Fixtures	47,720,118	112,343	0	112,343	3.00
4.00	Building Improvements	19,000	0	0	0	4.00
5.00	Fixed Equipment	30,154,386	436,283	0	436,283	5.00
6.00	Movable Equipment	36,008,280	1,448,785	0	1,448,785	6.00
7.00	HIT designated Assets	204,831	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	121,523,585	2,103,853	0	2,103,853	8.00
9.00	Reconciling Items	-268,806	-952,866	0	-952,866	9.00
10.00	Total (line 8 minus line 9)	121,792,391	3,056,719	0	3,056,719	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,129,972	0			1.00
2.00	Land Improvements	5,393,440	0			2.00
3.00	Buildings and Fixtures	47,832,461	0			3.00
4.00	Building Improvements	19,000	0			4.00
5.00	Fixed Equipment	30,590,669	0			5.00
6.00	Movable Equipment	37,034,144	0			6.00
7.00	HIT designated Assets	204,831	0			7.00
8.00	Subtotal (sum of lines 1-7)	123,204,517	0			8.00
9.00	Reconciling Items	-626,896	0			9.00
10.00	Total (line 8 minus line 9)	123,831,413	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0012

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

Worksheet A-7
Part II
Date/Time Prepared:
5/31/2017 3:55 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	5,486,672	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,486,672	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	5,486,672				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	5,486,672				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet A-7 Part III Date/Time Prepared: 5/31/2017 3:55 pm
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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	CAP REL COSTS-BLDG & FIXT	85,965,542	0	85,965,542	0.694214	68,537	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	37,865,871	0	37,865,871	0.305786	30,189	2.00
3.00	Total (sum of lines 1-2)	123,831,413	0	123,831,413	1.000000	98,726	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	68,537	3,972,445	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	30,189	1,490,007	0	2.00
3.00	Total (sum of lines 1-2)	0	0	98,726	5,462,452	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	389,110	68,537	0	0	4,430,092	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	65,888	30,189	0	0	1,586,084	2.00
3.00	Total (sum of lines 1-2)	454,998	98,726	0	0	6,016,176	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0012

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

Worksheet A-8

Date/Time Prepared:
5/31/2017 3:55 pm

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
				Cost Center		Line #		
				1.00	2.00	3.00		4.00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-122,895	CAP REL COSTS-BLDG & FIXT		1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-20,810	CAP REL COSTS-MVBLE EQUIP		2.00	11	2.00
3.00	Investment income - other (chapter 2)		0			0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-28,645	PURCHASING RECEIVING AND STORES		5.03	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-57,343	OTHER ADMIN & GENERAL		5.05	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0			0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-17,354	CASHIERING/ACCOUNTS RECEIVABLE		5.04	0	7.00
8.00	Television and radio service (chapter 21)	A	-20,654	OPERATION OF PLANT		7.00	0	8.00
9.00	Parking lot (chapter 21)		0			0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-21,316,729				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	B	-412,011	CAFETERIA		11.00	0	14.00
15.00	Rental of quarters to employee and others		0			0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0			0.00	0	16.00
17.00	Sale of drugs to other than patients		0			0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-54,413	MEDICAL RECORDS & LIBRARY		16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0			0.00	0	19.00
20.00	Vending machines		0			0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY		65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY		66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***		114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT		1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP		2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***		19.00		28.00
29.00	Physicians' assistant		0			0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY		67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS		30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY		68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00	MISC REV	B	-23,937	OTHER ADMIN & GENERAL		5.05	0	33.00
35.00	NON ALLOWABLE A&G	A	-508,119	OTHER ADMIN & GENERAL		5.05	0	35.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0012

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

Worksheet A-8

Date/Time Prepared:
5/31/2017 3:55 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
36.00 EMS TUITION	B	-4,190	EMERGENCY	91.00	0	36.00
36.01 EDUCATION REV (LIFE SUPPORT)	B	-14,081	NURSING ADMINISTRATION	13.00	0	36.01
37.00 SALE OF RADIOLOGY COPIES	B	-1,235	RADIOLOGY-DIAGNOSTIC	54.00	0	37.00
38.00 NON ALLOW ADVERTISING	A	-80,930	OTHER ADMIN & GENERAL	5.05	0	38.00
40.00 GRANT REVENUE	B	-192,770	NURSING ADMINISTRATION	13.00	0	40.00
40.01 RENTAL REVENUE	B	-351,980	OPERATION OF PLANT	7.00	0	40.01
40.02 AHA & IHA LOBBYING DUES	A	-34,439	OTHER ADMIN & GENERAL	5.05	0	40.02
41.00 EMPLOYEE PHYSICALS	A	-25,900	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.00
42.00 PHYSICIAN RECRUITMENT COSTS	A	-43,067	OTHER ADMIN & GENERAL	5.05	0	42.00
43.00 IPA TAX	A	-2,787,543	OTHER ADMIN & GENERAL	5.05	0	43.00
44.00 LEE COUNTY JAIL CAFETERIA REVENUE	B	-886	DIETARY	10.00	0	44.00
44.01 INTEREST INCOME	A	-20,454	OTHER ADMIN & GENERAL	5.05	0	44.01
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-26,140,385				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0012

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

Worksheet A-8-2

Date/Time Prepared:
5/31/2017 3:55 pm

	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	40.00	SUBPROVIDER - IPF	225,376	225,376	0	181,300	0	1.00
2.00	53.00	ANESTHESIOLOGY	926,806	926,806	0	239,400	0	2.00
3.00	60.00	LABORATORY	592,887	488,029	104,858	260,300	738	3.00
4.00	65.00	RESPIRATORY THERAPY	1,100	1,100	0	211,500	0	4.00
5.00	71.01	PSYCHIATRY/PSYCHOLOGICAL SERVICE	99,645	99,645	0	181,300	0	5.00
6.00	90.01	PROVIDER BASED CLINICS	17,470,978	17,352,217	118,761	211,500	987	6.00
7.00	91.00	EMERGENCY	2,628,906	1,348,569	1,280,337	211,500	4,596	7.00
8.00	16.00	MEDICAL RECORDS & LIBRARY	74,131	74,131	0	181,300	0	8.00
9.00	17.01	UTILIZATION REVIEW	3,117	3,117	0	181,300	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			22,022,946	20,518,990	1,503,956		6,321	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	40.00	SUBPROVIDER - IPF	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	4,696	2.00
3.00	60.00	LABORATORY	92,357	4,618	10,071	1,781	6,198	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	1,275	0	0	4.00
5.00	71.01	PSYCHIATRY/PSYCHOLOGICAL SERVICE	0	0	6,085	0	0	5.00
6.00	90.01	PROVIDER BASED CLINICS	100,361	5,018	146,564	996	448,725	6.00
7.00	91.00	EMERGENCY	467,334	23,367	38,334	18,670	42,240	7.00
8.00	16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	8.00
9.00	17.01	UTILIZATION REVIEW	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			660,052	33,003	202,329	21,447	501,859	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	40.00	SUBPROVIDER - IPF	0	0	0	225,376		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	926,806		2.00
3.00	60.00	LABORATORY	1,096	95,234	9,624	497,653		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	1,100		4.00
5.00	71.01	PSYCHIATRY/PSYCHOLOGICAL SERVICE	0	0	0	99,645		5.00
6.00	90.01	PROVIDER BASED CLINICS	3,050	104,407	14,354	17,366,571		6.00
7.00	91.00	EMERGENCY	20,572	506,576	773,761	2,122,330		7.00
8.00	16.00	MEDICAL RECORDS & LIBRARY	0	0	0	74,131		8.00
9.00	17.01	UTILIZATION REVIEW	0	0	0	3,117		9.00
10.00	0.00		0	0	0	0		10.00
200.00			24,718	706,217	797,739	21,316,729		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0012

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

Worksheet B
Part I
Date/Time Prepared:
5/31/2017 3:55 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	4,430,092	4,430,092			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,586,084		1,586,084		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	16,170,196	44,752	2,555	16,217,503	4.00
5.01 00540	NONPATIENT TELEPHONES	475,085	4,965	0	55,373	535,423 5.01
5.02 00590	DATA PROCESSING	4,363,874	78,845	240,400	168,564	20,661 5.02
5.03 00591	PURCHASING RECEIVING AND STORES	1,125,579	120,568	10,102	97,602	5,903 5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	2,317,880	122,594	4,029	412,798	35,419 5.04
5.05 00592	OTHER ADMIN & GENERAL	6,652,168	118,622	81,110	902,546	35,419 5.05
7.00 00700	OPERATION OF PLANT	2,742,495	1,354,611	48,210	228,094	23,613 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	284,711	1,793	0	0	0 8.00
9.00 00900	HOUSEKEEPING	1,063,264	39,514	0	162,298	2,361 9.00
10.00 01000	DIETARY	776,211	54,863	1,919	194,499	8,855 10.00
11.00 01100	CAFETERIA	442,398	36,890	12,993	80,402	0 11.00
13.00 01300	NURSING ADMINISTRATION	1,317,702	26,039	147,441	308,653	8,855 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	15,687	6,444	1,085	0	1,181 14.00
15.00 01500	PHARMACY	1,450,000	25,998	41,950	216,539	7,674 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,402,430	50,973	20,138	246,519	16,529 16.00
17.00 01700	SOCIAL SERVICE	72,091	0	0	18,790	0 17.00
17.01 01701	UTILIZATION REVIEW	173,193	1,408	0	46,015	1,771 17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES A	853,030	0	0	70,367	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A	1,288,319	41,641	7,556	301,838	11,216 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	4,036,305	437,823	81,403	972,830	41,323 30.00
31.00 03100	INTENSIVE CARE UNIT	1,422,261	44,965	37,257	312,262	5,903 31.00
40.00 04000	SUBPROVIDER - I/PF	1,139,502	64,874	4,220	290,218	7,084 40.00
43.00 04300	NURSERY	431,559	4,215	4,237	102,903	1,181 43.00
46.00 04600	OTHER LONG TERM CARE	0	0	0	0	0 46.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,782,456	274,297	309,393	493,942	21,252 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	107,446	12,624	3,482	22,993	590 52.00
53.00 05300	ANESTHESIOLOGY	114,736	861	13,900	260,040	0 53.00
53.01 03950	PAIN MANAGEMENT	0	0	0	0	0 53.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,448,213	71,844	109,050	378,433	15,348 54.00
54.01 05401	ULTRASOUND	524,407	2,877	934	105,151	1,181 54.01
57.00 05700	CT SCAN	350,136	5,745	174	34,347	1,181 57.00
58.00 05800	MRI	363,552	5,025	7,203	50,227	1,181 58.00
59.00 05900	CARDIAC CATHETERIZATION	457,016	55,188	0	86,601	4,723 59.00
60.00 06000	LABORATORY	4,583,560	56,393	122,910	653,363	17,710 60.00
65.00 06500	RESPIRATORY THERAPY	811,168	12,766	54,323	183,195	5,313 65.00
66.00 06600	PHYSICAL THERAPY	1,734,570	90,274	17,923	387,103	12,397 66.00
67.00 06700	OCCUPATIONAL THERAPY	406,959	0	0	87,005	1,771 67.00
68.00 06800	SPEECH PATHOLOGY	336,693	17,731	152	85,658	2,361 68.00
69.00 06900	ELECTROCARDIOLOGY	1,368,210	1,418	50,286	213,443	2,361 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	253,907	16,515	6,773	60,359	1,181 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	496,011	0	0	0	0 71.00
71.01 07101	PSYCHIATRIC/PSYCHOLOGICAL SERV	216,001	28,896	580	81,963	5,903 71.01
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	5,088,008	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,090,656	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0 90.00
90.01 09001	PROVIDER BASED CLINICS	9,881,229	903,619	111,745	6,480,259	175,325 90.01
91.00 09100	EMERGENCY	2,970,984	142,138	30,218	1,230,997	22,432 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	578,129	37,133	433	133,314	7,084 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	95,996,163	4,417,741	1,586,084	16,217,503	534,242 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	12,351	0	0	1,181 190.00
194.00 07950	MEALS ON WHEELS	0	0	0	0	0 194.00
194.01 07951	RETAIL PHARMACY	1,099,521	0	0	0	0 194.01
194.02 07952	IHAP	0	0	0	0	0 194.02
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)	97,095,684	4,430,092	1,586,084	16,217,503	535,423 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0012

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

Worksheet B Part I Date/Time Prepared: 5/31/2017 3:55 pm

Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN & GENERAL	
			5.02	5.03	5.04	5A.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	DATA PROCESSING	4,872,344					5.02
5.03	00591	PURCHASING RECEIVING AND STORES	86,127	1,445,881				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	289,142	2,172	3,184,034			5.04
5.05	00592	OTHER ADMIN & GENERAL	332,205	6,371	0	8,128,441	8,128,441	5.05
7.00	00700	OPERATION OF PLANT	73,823	39,131	0	4,509,977	412,050	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	286,504	26,176	8.00
9.00	00900	HOUSEKEEPING	0	13,311	0	1,280,748	117,014	9.00
10.00	01000	DIETARY	36,912	599	0	1,073,858	98,112	10.00
11.00	01100	CAFETERIA	0	4,058	0	576,741	52,693	11.00
13.00	01300	NURSING ADMINISTRATION	215,318	2,820	0	2,026,828	185,179	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,304	0	0	36,701	3,353	14.00
15.00	01500	PHARMACY	79,975	2,721	0	1,824,857	166,726	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	153,799	23,017	0	3,913,405	357,544	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	90,881	8,303	17.00
17.01	01701	UTILIZATION REVIEW	24,608	0	0	246,995	22,566	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	923,397	84,365	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	61,519	4,820	0	1,716,909	156,864	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	190,710	28,772	180,696	5,969,862	545,430	30.00
31.00	03100	INTENSIVE CARE UNIT	43,064	9,352	29,991	1,905,055	174,053	31.00
40.00	04000	SUBPROVIDER - IPF	43,064	1,021	69,750	1,619,733	147,985	40.00
43.00	04300	NURSERY	0	6,354	10,530	560,979	51,253	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	221,470	101,464	346,777	4,551,051	415,802	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,550	11,685	160,370	14,652	52.00
53.00	05300	ANESTHESIOLOGY	0	13,270	44,174	446,981	40,838	53.00
53.01	03950	PAIN MANAGEMENT	0	0	0	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	153,799	29,115	113,297	3,319,099	303,246	54.00
54.01	05401	ULTRASOUND	0	5,228	59,514	699,292	63,890	54.01
57.00	05700	CT SCAN	6,152	10,194	269,534	677,463	61,896	57.00
58.00	05800	MRI	6,152	22,948	97,899	554,187	50,633	58.00
59.00	05900	CARDIAC CATHETERIZATION	86,127	90,170	266,176	1,046,001	95,567	59.00
60.00	06000	LABORATORY	184,558	193,923	377,892	6,190,309	565,571	60.00
65.00	06500	RESPIRATORY THERAPY	55,368	13,877	115,395	1,251,405	114,333	65.00
66.00	06600	PHYSICAL THERAPY	203,014	6,172	98,971	2,550,424	233,017	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	826	15,621	512,182	46,795	67.00
68.00	06800	SPEECH PATHOLOGY	36,912	15,475	9,759	504,741	46,115	68.00
69.00	06900	ELECTROCARDIOLOGY	36,912	194,551	92,255	1,959,436	179,022	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	30,760	2,531	25,764	397,790	36,344	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	441,668	284,093	1,221,772	111,626	71.00
71.01	07101	PSYCHIATRY/PSYCHOLOGICAL SERV	73,823	70	8,584	415,820	37,991	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	51,432	5,139,440	469,560	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,401	396,618	2,508,675	229,203	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINICS	1,882,497	102,662	0	19,537,336	1,785,049	90.01
91.00	09100	EMERGENCY	166,103	30,948	196,619	4,790,439	437,674	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	86,127	3,319	11,008	856,547	78,258	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,872,344	1,445,881	3,184,034	95,982,631	8,026,748	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	13,532	1,236	190.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	0	0	1,099,521	100,457	194.01
194.02	07952	IHAP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers				0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,872,344	1,445,881	3,184,034	97,095,684	8,128,441	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0012

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

Worksheet B Part I Date/Time Prepared: 5/31/2017 3:55 pm

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	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00590	DATA PROCESSING					5.02
5.03	00591	PURCHASING RECEIVING AND STORES					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00592	OTHER ADMIN & GENERAL					5.05
7.00	00700	OPERATION OF PLANT	4,922,027				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,414	316,094			8.00
9.00	00900	HOUSEKEEPING	75,233	0	1,472,995		9.00
10.00	01000	DIETARY	104,458	0	10,117	1,286,545	10.00
11.00	01100	CAFETERIA	70,237	0	13,489	0	713,160
13.00	01300	NURSING ADMINISTRATION	49,577	0	7,419	0	12,512
14.00	01400	CENTRAL SERVICES & SUPPLY	12,269	0	18,210	0	1,787
15.00	01500	PHARMACY	49,500	0	17,536	0	17,874
16.00	01600	MEDICAL RECORDS & LIBRARY	97,051	0	40,467	0	26,811
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
17.01	01701	UTILIZATION REVIEW	2,681	0	1,349	0	5,362
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	79,284	0	0	0	19,661
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	833,603	94,030	304,176	642,937	100,093
31.00	03100	INTENSIVE CARE UNIT	85,612	16,887	39,118	83,004	26,811
40.00	04000	SUBPROVIDER - IPF	123,518	7,956	46,537	183,211	26,811
43.00	04300	NURSERY	8,025	5,511	7,419	0	5,362
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	522,254	69,225	269,779	24,689	60,771
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,036	3,080	16,861	0	1,787
53.00	05300	ANESTHESIOLOGY	1,640	0	0	0	0
53.01	03950	PAIN MANAGEMENT	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	136,789	7,451	51,933	0	32,173
54.01	05401	ULTRASOUND	5,479	3,894	2,698	0	7,149
57.00	05700	CT SCAN	10,938	17,633	5,396	0	3,575
58.00	05800	MRI	9,568	6,404	4,721	0	5,362
59.00	05900	CARDIAC CATHETERIZATION	105,076	3,582	15,512	0	0
60.00	06000	LABORATORY	107,371	0	39,118	0	51,834
65.00	06500	RESPIRATORY THERAPY	24,306	0	57,328	0	14,299
66.00	06600	PHYSICAL THERAPY	171,879	10,022	56,654	0	26,811
67.00	06700	OCCUPATIONAL THERAPY	0	0	16,861	0	5,362
68.00	06800	SPEECH PATHOLOGY	33,758	0	6,744	0	7,149
69.00	06900	ELECTROCARDIOLOGY	2,701	0	3,372	0	26,811
70.00	07000	ELECTROENCEPHALOGRAPHY	31,444	0	6,744	0	3,575
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0
71.01	07101	PSYCHIATRIC/PSYCHOLOGICAL SERV	55,017	0	11,466	0	7,149
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	PROVIDER BASED CLINICS	1,720,467	0	200,986	0	139,412
91.00	09100	EMERGENCY	270,627	70,419	178,054	0	60,771
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	70,700	0	12,140	0	16,086
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,898,512	316,094	1,462,204	933,841	713,160
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	23,515	0	10,791	0	0
194.00	07950	MEALS ON WHEELS	0	0	0	352,704	0
194.01	07951	RETAIL PHARMACY	0	0	0	0	0
194.02	07952	IHAP	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	4,922,027	316,094	1,472,995	1,286,545	713,160

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0012

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

Worksheet B
Part I
Date/Time Prepared:
5/31/2017 3:55 pm

Cost Center Description			NURSING ADMINISTRATION	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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	DATA PROCESSING						5.02
5.03	00591	PURCHASING RECEIVING AND STORES						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00592	OTHER ADMIN & GENERAL						5.05
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	2,281,515					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	72,320				14.00
15.00	01500	PHARMACY	0	0	2,076,493			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	4,435,278		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	99,184	17.00
17.01	01701	UTILIZATION REVIEW	0	0	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES A	31,537	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	69,743	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	353,904	0	668	685,095	62,411	30.00
31.00	03100	INTENSIVE CARE UNIT	110,434	0	170	120,687	8,930	31.00
40.00	04000	SUBPROVIDER - IPF	110,305	0	28	280,686	22,658	40.00
43.00	04300	NURSERY	28,599	0	0	42,374	5,185	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	174,145	0	1,438	352,822	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,247	0	20	44,700	0	52.00
53.00	05300	ANESTHESIOLOGY	268	0	0	54,043	0	53.00
53.01	03950	PAIN MANAGEMENT	0	0	0	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,853	36,034	0	54.00
54.01	05401	ULTRASOUND	0	0	545	20,352	0	54.01
57.00	05700	CT SCAN	0	0	210	176,496	0	57.00
58.00	05800	MRI	0	0	132	16,631	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	455	336,946	0	59.00
60.00	06000	LABORATORY	0	0	139	355,729	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,464	0	11,902	334,333	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	195	31,391	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	8,833	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,158	0	68.00
69.00	06900	ELECTROCARDIOLOGY	77,186	0	0	73,338	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	22,873	0	0	628	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	72,320	0	467,299	0	71.00
71.01	07101	PSYCHIATRY/PSYCHOLOGICAL SERV	19,743	0	0	21,253	0	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	26,150	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	710,105	809,701	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINICS	1,046,465	0	427,863	0	0	90.01
91.00	09100	EMERGENCY	171,394	0	637	127,068	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	52,208	0	4	9,531	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,281,515	72,320	1,158,364	4,435,278	99,184	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	0	918,129	0	0	194.01
194.02	07952	IHAP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,281,515	72,320	2,076,493	4,435,278	99,184	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0012

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

Worksheet B
Part I
Date/Time Prepared:
5/31/2017 3:55 pm

Cost Center Description	UTILIZATION REVIEW	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		SERVICES-SALARY & FRINGES A	SERVICES-OTHER PRGM COSTS A			
	17.01	21.00	22.00	24.00	25.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00540	NONPATIENT TELEPHONES					5.01
5.02 00590	DATA PROCESSING					5.02
5.03 00591	PURCAHSING RECEIVING AND STORES					5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05 00592	OTHER ADMIN & GENERAL					5.05
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
17.01 01701	UTILIZATION REVIEW	278,953				17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES A	0	1,039,299			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A	0		2,042,461		22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	175,529	847,603	1,665,733	12,281,074	-2,513,336 30.00
31.00 03100	INTENSIVE CARE UNIT	25,116	121,282	238,347	2,955,506	-359,629 31.00
40.00 04000	SUBPROVIDER - I PF	63,726	0	0	2,633,154	0 40.00
43.00 04300	NURSERY	14,582	70,414	138,381	938,084	-208,795 43.00
46.00 04600	OTHER LONG TERM CARE	0	0	0	0	0 46.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	6,441,976	0 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	271,753	0 52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	543,770	0 53.00
53.01 03950	PAIN MANAGEMENT	0	0	0	0	0 53.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,890,578	0 54.00
54.01 05401	ULTRASOUND	0	0	0	803,299	0 54.01
57.00 05700	CT SCAN	0	0	0	953,607	0 57.00
58.00 05800	MRI	0	0	0	647,638	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	1,603,139	0 59.00
60.00 06000	LABORATORY	0	0	0	7,310,071	0 60.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	1,814,370	0 65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	3,080,393	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	590,033	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	601,665	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	2,321,866	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	499,398	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	1,873,017	0 71.00
71.01 07101	PSYCHIATRY/PSYCHOLOGICAL SERV	0	0	0	568,439	0 71.01
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,635,150	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,257,684	0 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0 90.00
90.01 09001	PROVIDER BASED CLINICS	0	0	0	24,857,578	0 90.01
91.00 09100	EMERGENCY	0	0	0	6,107,083	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	0	0	1,095,474	0 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	278,953	1,039,299	2,042,461	94,575,799	-3,081,760 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	49,074	0 190.00
194.00 07950	MEALS ON WHEELS	0	0	0	352,704	0 194.00
194.01 07951	RETAIL PHARMACY	0	0	0	2,118,107	0 194.01
194.02 07952	IHAP	0	0	0	0	0 194.02
200.00	Cross Foot Adjustments				0	0 200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	278,953	1,039,299	2,042,461	97,095,684	-3,081,760 202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prepared: 5/31/2017 3:55 pm
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00540	NONPATIENT TELEPHONES	5.01
5.02	00590	DATA PROCESSING	5.02
5.03	00591	PURCAHSING RECEIVING AND STORES	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.04
5.05	00592	OTHER ADMIN & GENERAL	5.05
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
17.01	01701	UTILIZATION REVIEW	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES A	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	22.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
46.00	04600	OTHER LONG TERM CARE	46.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
53.01	03950	PAIN MANAGEMENT	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	71.00
71.01	07101	PSYCHIATRY/PSYCHOLOGICAL SERV	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	PROVIDER BASED CLINICS	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	190.00
194.00	07950	MEALS ON WHEELS	194.00
194.01	07951	RETAIL PHARMACY	194.01
194.02	07952	IHAP	194.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0012

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

Worksheet B
Part II
Date/Time Prepared:
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	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
			0	1.00			
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400	0	44,752	2,555	47,307	47,307	4.00
5.01	00540	0	4,965	0	4,965	161	5.01
5.02	00590	3,757	78,845	240,400	323,002	491	5.02
5.03	00591	181,271	120,568	10,102	311,941	285	5.03
5.04	00580	0	122,594	4,029	126,623	1,203	5.04
5.05	00592	5,358	118,622	81,110	205,090	2,631	5.05
7.00	00700	92,218	1,354,611	48,210	1,495,039	665	7.00
8.00	00800	0	1,793	0	1,793	0	8.00
9.00	00900	0	39,514	0	39,514	473	9.00
10.00	01000	0	54,863	1,919	56,782	567	10.00
11.00	01100	0	36,890	12,993	49,883	234	11.00
13.00	01300	0	26,039	147,441	173,480	900	13.00
14.00	01400	3,420	6,444	1,085	10,949	0	14.00
15.00	01500	148,760	25,998	41,950	216,708	631	15.00
16.00	01600	0	50,973	20,138	71,111	719	16.00
17.00	01700	0	0	0	0	55	17.00
17.01	01701	0	1,408	0	1,408	134	17.01
21.00	02100	0	0	0	0	205	21.00
22.00	02200	0	41,641	7,556	49,197	880	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	7,275	437,823	81,403	526,501	2,836	30.00
31.00	03100	614	44,965	37,257	82,836	910	31.00
40.00	04000	0	64,874	4,220	69,094	846	40.00
43.00	04300	0	4,215	4,237	8,452	300	43.00
46.00	04600	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	381,858	274,297	309,393	965,548	1,440	50.00
52.00	05200	0	12,624	3,482	16,106	67	52.00
53.00	05300	6,982	861	13,900	21,743	758	53.00
53.01	03950	0	0	0	0	0	53.01
54.00	05400	4,386	71,844	109,050	185,280	1,103	54.00
54.01	05401	64,164	2,877	934	67,975	307	54.01
57.00	05700	0	5,745	174	5,919	100	57.00
58.00	05800	0	5,025	7,203	12,228	146	58.00
59.00	05900	0	55,188	0	55,188	252	59.00
60.00	06000	80,021	56,393	122,910	259,324	1,905	60.00
65.00	06500	1,437	12,766	54,323	68,526	534	65.00
66.00	06600	35,759	90,274	17,923	143,956	1,129	66.00
67.00	06700	0	0	0	0	254	67.00
68.00	06800	0	17,731	152	17,883	250	68.00
69.00	06900	213,684	1,418	50,286	265,388	622	69.00
70.00	07000	827	16,515	6,773	24,115	176	70.00
71.00	07100	0	0	0	0	0	71.00
71.01	07101	0	28,896	580	29,476	239	71.01
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	298,398	903,619	111,745	1,313,762	18,921	90.01
91.00	09100	0	142,138	30,218	172,356	3,589	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	37,133	433	37,566	389	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		1,530,189	4,417,741	1,586,084	7,534,014	47,307	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	12,351	0	12,351	0	190.00
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
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,530,189	4,430,092	1,586,084	7,546,365	47,307	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0012		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 5/31/2017 3:55 pm	
Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMIN & GENERAL	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	5,126					5.01
5.02	00590	DATA PROCESSING	198	323,691				5.02
5.03	00591	PURCHASING RECEIVING AND STORES	57	5,722	318,005			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	339	19,209	478	147,852		5.04
5.05	00592	OTHER ADMIN & GENERAL	339	22,070	1,401	0	231,531	5.05
7.00	00700	OPERATION OF PLANT	226	4,904	8,606	0	11,735	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	745	8.00
9.00	00900	HOUSEKEEPING	23	0	2,928	0	3,333	9.00
10.00	01000	DIETARY	85	2,452	132	0	2,794	10.00
11.00	01100	CAFETERIA	0	0	893	0	1,501	11.00
13.00	01300	NURSING ADMINISTRATION	85	14,305	620	0	5,274	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11	817	0	0	95	14.00
15.00	01500	PHARMACY	73	5,313	598	0	4,748	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	158	10,218	5,062	0	10,183	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	236	17.00
17.01	01701	UTILIZATION REVIEW	17	1,635	0	0	643	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	2,403	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	107	4,087	1,060	0	4,467	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	396	12,670	6,328	8,386	15,534	30.00
31.00	03100	INTENSIVE CARE UNIT	57	2,861	2,057	1,392	4,957	31.00
40.00	04000	SUBPROVIDER - IPF	68	2,861	225	3,237	4,215	40.00
43.00	04300	NURSERY	11	0	1,398	489	1,460	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	203	14,713	22,316	16,094	11,842	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6	0	341	542	417	52.00
53.00	05300	ANESTHESIOLOGY	0	0	2,919	2,050	1,163	53.00
53.01	03950	PAIN MANAGEMENT	0	0	0	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	147	10,218	6,404	5,258	8,636	54.00
54.01	05401	ULTRASOUND	11	0	1,150	2,762	1,820	54.01
57.00	05700	CT SCAN	11	409	2,242	12,509	1,763	57.00
58.00	05800	MRI	11	409	5,047	4,544	1,442	58.00
59.00	05900	CARDIAC CATHETERIZATION	45	5,722	19,832	12,354	2,722	59.00
60.00	06000	LABORATORY	170	12,261	42,651	17,538	16,107	60.00
65.00	06500	RESPIRATORY THERAPY	51	3,678	3,052	5,356	3,256	65.00
66.00	06600	PHYSICAL THERAPY	119	13,487	1,357	4,593	6,636	66.00
67.00	06700	OCCUPATIONAL THERAPY	17	0	182	725	1,333	67.00
68.00	06800	SPEECH PATHOLOGY	23	2,452	3,404	453	1,313	68.00
69.00	06900	ELECTROCARDIOLOGY	23	2,452	42,789	4,282	5,098	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	11	2,044	557	1,196	1,035	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	97,138	13,185	3,179	71.00
71.01	07101	PSYCHIATRY/PSYCHOLOGICAL SERV	57	4,904	15	398	1,082	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,387	13,373	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,707	18,486	6,528	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINICS	1,677	125,061	22,579	0	50,873	90.01
91.00	09100	EMERGENCY	215	11,035	6,807	9,125	12,465	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	68	5,722	730	511	2,229	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,115	323,691	318,005	147,852	228,635	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	11	0	0	0	35	190.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	0	0	0	2,861	194.01
194.02	07952	IHAP	0	0	0	0	0	194.02
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)	5,126	323,691	318,005	147,852	231,531	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0012

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

Worksheet B
Part II
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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	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00590	DATA PROCESSING					5.02
5.03	00591	PURCHASING RECEIVING AND STORES					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00592	OTHER ADMIN & GENERAL					5.05
7.00	00700	OPERATION OF PLANT	1,521,175				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,055	3,593			8.00
9.00	00900	HOUSEKEEPING	23,251	0	69,522		9.00
10.00	01000	DIETARY	32,283	0	477	95,572	10.00
11.00	01100	CAFETERIA	21,707	0	637	0	74,855
13.00	01300	NURSING ADMINISTRATION	15,322	0	350	0	1,313
14.00	01400	CENTRAL SERVICES & SUPPLY	3,792	0	859	0	188
15.00	01500	PHARMACY	15,298	0	828	0	1,876
16.00	01600	MEDICAL RECORDS & LIBRARY	29,994	0	1,910	0	2,814
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
17.01	01701	UTILIZATION REVIEW	829	0	64	0	563
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	24,503	0	0	0	2,064
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	257,629	1,069	14,358	47,761	10,506
31.00	03100	INTENSIVE CARE UNIT	26,459	192	1,846	6,166	2,814
40.00	04000	SUBPROVIDER - IPF	38,174	90	2,196	13,610	2,814
43.00	04300	NURSERY	2,480	63	350	0	563
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	161,405	787	12,733	1,834	6,379
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,428	35	796	0	188
53.00	05300	ANESTHESIOLOGY	507	0	0	0	0
53.01	03950	PAIN MANAGEMENT	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,275	85	2,451	0	3,377
54.01	05401	ULTRASOUND	1,693	44	127	0	750
57.00	05700	CT SCAN	3,380	200	255	0	375
58.00	05800	MRI	2,957	73	223	0	563
59.00	05900	CARDIAC CATHETERIZATION	32,474	41	732	0	0
60.00	06000	LABORATORY	33,184	0	1,846	0	5,441
65.00	06500	RESPIRATORY THERAPY	7,512	0	2,706	0	1,501
66.00	06600	PHYSICAL THERAPY	53,120	114	2,674	0	2,814
67.00	06700	OCCUPATIONAL THERAPY	0	0	796	0	563
68.00	06800	SPEECH PATHOLOGY	10,433	0	318	0	750
69.00	06900	ELECTROCARDIOLOGY	835	0	159	0	2,814
70.00	07000	ELECTROENCEPHALOGRAPHY	9,718	0	318	0	375
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0
71.01	07101	PSYCHIATRY/PSYCHOLOGICAL SERV	17,003	0	541	0	750
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	PROVIDER BASED CLINICS	531,719	0	9,486	0	14,633
91.00	09100	EMERGENCY	83,639	800	8,404	0	6,379
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	21,850	0	573	0	1,688
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,513,908	3,593	69,013	69,371	74,855
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	7,267	0	509	0	0
194.00	07950	MEALS ON WHEELS	0	0	0	26,201	0
194.01	07951	RETAIL PHARMACY	0	0	0	0	0
194.02	07952	IHAP	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,521,175	3,593	69,522	95,572	74,855

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0012

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

Worksheet B
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Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATION	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
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00590						5.02
5.03	00591						5.03
5.04	00580						5.04
5.05	00592						5.05
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	211,649					13.00
14.00	01400	0	16,711				14.00
15.00	01500	0	0	246,073			15.00
16.00	01600	0	0	0	132,169		16.00
17.00	01700	0	0	0	0	291	17.00
17.01	01701	0	0	0	0	0	17.01
21.00	02100	2,926	0	0	0	0	21.00
22.00	02200	6,470	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	32,830	0	79	20,423	184	30.00
31.00	03100	10,245	0	20	3,598	26	31.00
40.00	04000	10,233	0	3	8,367	66	40.00
43.00	04300	2,653	0	0	1,263	15	43.00
46.00	04600	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	16,155	0	170	10,518	0	50.00
52.00	05200	579	0	2	1,333	0	52.00
53.00	05300	25	0	0	1,611	0	53.00
53.01	03950	0	0	0	0	0	53.01
54.00	05400	0	0	457	1,074	0	54.00
54.01	05401	0	0	65	607	0	54.01
57.00	05700	0	0	25	5,261	0	57.00
58.00	05800	0	0	16	496	0	58.00
59.00	05900	0	0	54	10,044	0	59.00
60.00	06000	0	0	16	10,604	0	60.00
65.00	06500	600	0	1,410	9,967	0	65.00
66.00	06600	0	0	23	936	0	66.00
67.00	06700	0	0	0	263	0	67.00
68.00	06800	0	0	0	94	0	68.00
69.00	06900	7,160	0	0	2,186	0	69.00
70.00	07000	2,122	0	0	19	0	70.00
71.00	07100	0	16,711	0	13,930	0	71.00
71.01	07101	1,832	0	0	634	0	71.01
72.00	07200	0	0	0	780	0	72.00
73.00	07300	0	0	84,151	24,089	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	97,076	0	50,704	0	0	90.01
91.00	09100	15,900	0	76	3,788	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	4,843	0	0	284	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		211,649	16,711	137,271	132,169	291	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	108,802	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		211,649	16,711	246,073	132,169	291	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/31/2017 3:55 pm
Cost Center Description	UTILIZATION REVIEW	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
		SERVICES-SALARY & FRINGES A	SERVICES-OTHER PRGM COSTS A		
	17.01	21.00	22.00	24.00	25.00
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540	NONPATIENT TELEPHONES			5.01
5.02	00590	DATA PROCESSING			5.02
5.03	00591	PURCHASING RECEIVING AND STORES			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.04
5.05	00592	OTHER ADMIN & GENERAL			5.05
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
17.01	01701	UTILIZATION REVIEW	5,293		17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	5,534	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	92,835	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,330		30.00
31.00	03100	INTENSIVE CARE UNIT	477		31.00
40.00	04000	SUBPROVIDER - IPF	1,209		40.00
43.00	04300	NURSERY	277		43.00
46.00	04600	OTHER LONG TERM CARE	0		46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,242,137	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	27,840	52.00
53.00	05300	ANESTHESIOLOGY	0	30,776	53.00
53.01	03950	PAIN MANAGEMENT	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	266,765	54.00
54.01	05401	ULTRASOUND	0	77,311	54.01
57.00	05700	CT SCAN	0	32,449	57.00
58.00	05800	MRI	0	28,155	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	139,460	59.00
60.00	06000	LABORATORY	0	401,047	60.00
65.00	06500	RESPIRATORY THERAPY	0	108,149	65.00
66.00	06600	PHYSICAL THERAPY	0	230,958	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,133	67.00
68.00	06800	SPEECH PATHOLOGY	0	37,373	68.00
69.00	06900	ELECTROCARDIOLOGY	0	333,808	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	41,686	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	144,143	71.00
71.01	07101	PSYCHIATRIC/PSYCHOLOGICAL SERV	0	56,931	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	16,540	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	137,961	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	PROVIDER BASED CLINICS	0	2,236,491	90.01
91.00	09100	EMERGENCY	0	334,578	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	76,453	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,293	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	20,173	190.00
194.00	07950	MEALS ON WHEELS	0	26,201	194.00
194.01	07951	RETAIL PHARMACY	0	111,663	194.01
194.02	07952	IHAP	0	0	194.02
200.00		Cross Foot Adjustments	5,534	92,835	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,293	5,534	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/31/2017 3:55 pm
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00540	NONPATIENT TELEPHONES	5.01
5.02	00590	DATA PROCESSING	5.02
5.03	00591	PURCAHSING RECEIVING AND STORES	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.04
5.05	00592	OTHER ADMIN & GENERAL	5.05
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
17.01	01701	UTILIZATION REVIEW	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES A	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	22.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
46.00	04600	OTHER LONG TERM CARE	46.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
53.01	03950	PAIN MANAGEMENT	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	71.00
71.01	07101	PSYCHIATRY/PSYCHOLOGICAL SERV	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	PROVIDER BASED CLINICS	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	190.00
194.00	07950	MEALS ON WHEELS	194.00
194.01	07951	RETAIL PHARMACY	194.01
194.02	07952	IHAP	194.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0012

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

Worksheet B-1
Date/Time Prepared:
5/31/2017 3:55 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (TELEPHONES)	DATA PROCESSING (NUMBER OF MACHINES)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	437,249				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,490,007			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,417	2,400	57,800,611		4.00
5.01	00540	NONPATIENT TELEPHONES	490	0	197,353	907	5.01
5.02	00590	DATA PROCESSING	7,782	225,838	600,777	35	792 5.02
5.03	00591	PURCHASING RECEIVING AND STORES	11,900	9,490	347,862	10	14 5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	12,100	3,785	1,471,248	60	47 5.04
5.05	00592	OTHER ADMIN & GENERAL	11,708	76,197	3,216,749	60	54 5.05
7.00	00700	OPERATION OF PLANT	133,700	45,290	812,947	40	12 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	177	0	0	0	0 8.00
9.00	00900	HOUSEKEEPING	3,900	0	578,443	4	0 9.00
10.00	01000	DIETARY	5,415	1,803	693,212	15	6 10.00
11.00	01100	CAFETERIA	3,641	12,206	286,558	0	0 11.00
13.00	01300	NURSING ADMINISTRATION	2,570	138,510	1,100,065	15	35 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	636	1,019	0	2	2 14.00
15.00	01500	PHARMACY	2,566	39,409	771,764	13	13 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,031	18,918	878,613	28	25 16.00
17.00	01700	SOCIAL SERVICE	0	0	66,968	0	0 17.00
17.01	01701	UTILIZATION REVIEW	139	0	164,002	3	4 17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	250,795	0	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	4,110	7,098	1,075,777	19	10 22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	43,213	76,472	3,467,249	70	31 30.00
31.00	03100	INTENSIVE CARE UNIT	4,438	35,000	1,112,927	10	7 31.00
40.00	04000	SUBPROVIDER - IPF	6,403	3,964	1,034,360	12	7 40.00
43.00	04300	NURSERY	416	3,980	366,754	2	0 43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0 46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	27,073	290,652	1,760,451	36	36 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,246	3,271	81,948	1	0 52.00
53.00	05300	ANESTHESIOLOGY	85	13,058	926,806	0	0 53.00
53.01	03950	PAIN MANAGEMENT	0	0	0	0	0 53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,091	102,444	1,348,767	26	25 54.00
54.01	05401	ULTRASOUND	284	877	374,767	2	0 54.01
57.00	05700	CT SCAN	567	163	122,416	2	1 57.00
58.00	05800	MRI	496	6,767	179,015	2	1 58.00
59.00	05900	CARDIAC CATHETERIZATION	5,447	0	308,653	8	14 59.00
60.00	06000	LABORATORY	5,566	115,465	2,328,640	30	30 60.00
65.00	06500	RESPIRATORY THERAPY	1,260	51,032	652,924	9	9 65.00
66.00	06600	PHYSICAL THERAPY	8,910	16,837	1,379,666	21	33 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	310,093	3	0 67.00
68.00	06800	SPEECH PATHOLOGY	1,750	143	305,293	4	6 68.00
69.00	06900	ELECTROCARDIOLOGY	140	47,240	760,729	4	6 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,630	6,363	215,123	2	5 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0 71.00
71.01	07101	PSYCHIATRY/PSYCHOLOGICAL SERV	2,852	545	292,124	10	12 71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.01	09001	PROVIDER BASED CLINICS	89,187	104,976	23,096,257	297	306 90.01
91.00	09100	EMERGENCY	14,029	28,388	4,387,375	38	27 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	3,665	407	475,141	12	14 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	436,030	1,490,007	57,800,611	905	792 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	1,219	0	0	2	0 190.00
194.00	07950	MEALS ON WHEELS	0	0	0	0	0 194.00
194.01	07951	RETAIL PHARMACY	0	0	0	0	0 194.01
194.02	07952	IHAP	0	0	0	0	0 194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,430,092	1,586,084	16,217,503	535,423	4,872,344 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.131737	1.064481	0.280577	590.323043	6,151.949495 203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0012

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

Worksheet B-1

Date/Time Prepared:
5/31/2017 3:55 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (TELEPHONES)	DATA PROCESSING (NUMBER OF MACHINES)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
204.00	Cost to be allocated (per Wkst. B, Part II)			47,307	5,126	323,691	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000818	5.651599	408.700758	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0012

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

Worksheet B-1

Date/Time Prepared:
5/31/2017 3:55 pm

Cost Center Description		PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		5.03	5.04	5A.05	5.05	7.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00590	DATA PROCESSING					5.02
5.03	00591	PURCHASING RECEIVING AND STORES	10,123,665				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	15,206	352,665,129			5.04
5.05	00592	OTHER ADMIN & GENERAL	44,607	0	-8,128,441	88,967,243	5.05
7.00	00700	OPERATION OF PLANT	273,986	0	0	255,152	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	286,504	8.00
9.00	00900	HOUSEKEEPING	93,200	0	0	1,280,748	9.00
10.00	01000	DIETARY	4,197	0	0	1,073,858	10.00
11.00	01100	CAFETERIA	28,415	0	0	576,741	11.00
13.00	01300	NURSING ADMINISTRATION	19,748	0	0	2,026,828	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	36,701	14.00
15.00	01500	PHARMACY	19,052	0	0	1,824,857	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	161,156	0	0	3,913,405	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	90,881	17.00
17.01	01701	UTILIZATION REVIEW	0	0	0	246,995	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	923,397	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	33,751	0	0	1,716,909	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	201,453	20,015,033	0	5,969,862	30.00
31.00	03100	INTENSIVE CARE UNIT	65,478	3,321,964	0	1,905,055	31.00
40.00	04000	SUBPROVIDER - I/PF	7,148	7,725,998	0	1,619,733	40.00
43.00	04300	NURSERY	44,492	1,166,373	0	560,979	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	710,421	38,411,248	0	4,551,051	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,854	1,294,286	0	160,370	52.00
53.00	05300	ANESTHESIOLOGY	92,911	4,892,954	0	446,981	53.00
53.01	03950	PAIN MANAGEMENT	0	0	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	203,858	12,549,531	0	3,319,099	54.00
54.01	05401	ULTRASOUND	36,605	6,592,112	0	699,292	54.01
57.00	05700	CT SCAN	71,379	29,855,327	0	677,463	57.00
58.00	05800	MRI	160,674	10,843,895	0	554,187	58.00
59.00	05900	CARDIAC CATHETERIZATION	631,347	29,483,403	0	1,046,001	59.00
60.00	06000	LABORATORY	1,357,798	41,857,735	0	6,190,309	60.00
65.00	06500	RESPIRATORY THERAPY	97,160	12,781,908	0	1,251,405	65.00
66.00	06600	PHYSICAL THERAPY	43,213	10,962,623	0	2,550,424	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,781	1,730,330	0	512,182	67.00
68.00	06800	SPEECH PATHOLOGY	108,353	1,081,012	0	504,741	68.00
69.00	06900	ELECTROCARDIOLOGY	1,362,193	10,218,792	0	1,959,436	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17,722	2,853,745	0	397,790	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	3,092,429	31,467,979	0	1,221,772	71.00
71.01	07101	PSYCHIATRY/PSYCHOLOGICAL SERV	489	950,790	0	415,820	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,696,983	0	5,139,440	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	149,844	43,912,945	0	2,508,675	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINICS	718,811	0	0	19,537,336	90.01
91.00	09100	EMERGENCY	216,692	21,778,813	0	4,790,439	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	23,242	1,219,350	0	856,547	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,123,665	352,665,129	-8,128,441	87,854,190	253,933
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	13,532	1,219
194.00	07950	MEALS ON WHEELS	0	0	0	0	0
194.01	07951	RETAIL PHARMACY	0	0	0	1,099,521	0
194.02	07952	IHAP	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	1,445,881	3,184,034		8,128,441	4,922,027
203.00		Unit cost multiplier (Wkst. B, Part I)	0.142822	0.009028		0.091364	19.290568
204.00		Cost to be allocated (per Wkst. B, Part II)	318,005	147,852		231,531	1,521,175

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 14-0012		Period: From 01/01/2016 To 12/31/2016		Worksheet B-1 Date/Time Prepared: 5/31/2017 3:55 pm	
Cost Center Description		PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		5.03	5.04	5A.05	5.05	7.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.031412	0.000419		0.002602	5.961838	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0012

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

Worksheet B-1

Date/Time Prepared: 5/31/2017 3:55 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00590						5.02
5.03	00591						5.03
5.04	00580						5.04
5.05	00592						5.05
7.00	00700						7.00
8.00	00800	357,942					8.00
9.00	00900	0	2,184				9.00
10.00	01000	0	15	57,582			10.00
11.00	01100	0	20	0	399		11.00
13.00	01300	0	11	0	7	818,513	13.00
14.00	01400	0	27	0	1	0	14.00
15.00	01500	0	26	0	10	0	15.00
16.00	01600	0	60	0	15	0	16.00
17.00	01700	0	0	0	0	0	17.00
17.01	01701	0	2	0	3	0	17.01
21.00	02100	0	0	0	0	11,314	21.00
22.00	02200	0	0	0	11	25,021	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	106,478	451	28,776	56	126,966	30.00
31.00	03100	19,123	58	3,715	15	39,619	31.00
40.00	04000	9,009	69	8,200	15	39,573	40.00
43.00	04300	6,241	11	0	3	10,260	43.00
46.00	04600	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	78,390	400	1,105	34	62,476	50.00
52.00	05200	3,488	25	0	1	2,241	52.00
53.00	05300	0	0	0	0	96	53.00
53.01	03950	0	0	0	0	0	53.01
54.00	05400	8,438	77	0	18	0	54.00
54.01	05401	4,409	4	0	4	0	54.01
57.00	05700	19,967	8	0	2	0	57.00
58.00	05800	7,252	7	0	3	0	58.00
59.00	05900	4,056	23	0	0	0	59.00
60.00	06000	0	58	0	29	0	60.00
65.00	06500	0	85	0	8	2,319	65.00
66.00	06600	11,349	84	0	15	0	66.00
67.00	06700	0	25	0	3	0	67.00
68.00	06800	0	10	0	4	0	68.00
69.00	06900	0	5	0	15	27,691	69.00
70.00	07000	0	10	0	2	8,206	70.00
71.00	07100	0	0	0	0	0	71.00
71.01	07101	0	17	0	4	7,083	71.01
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	298	0	78	375,429	90.01
91.00	09100	79,742	264	0	34	61,489	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	18	0	9	18,730	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		357,942	2,168	41,796	399	818,513	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	16	0	0	0	190.00
194.00	07950	0	0	15,786	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00							201.00
202.00		316,094	1,472,995	1,286,545	713,160	2,281,515	202.00
203.00		0.883087	674.448260	22.342833	1,787.368421	2.787390	203.00
204.00		3,593	69,522	95,572	74,855	211,649	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0012

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

Worksheet B-1

Date/Time Prepared:
5/31/2017 3:55 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
		8.00	9.00	10.00	11.00	13.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.010038	31.832418	1.659755	187.606516	0.258577	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0012

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

Worksheet B-1
Date/Time Prepared:
5/31/2017 3:55 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUISITIONS)	PHARMACY (COSTED REQUISITIONS)	MEDICAL RECORDS & LIBRARY (I/P GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	UTILIZATION REVIEW (PATIENT DAYS)		
		14.00	15.00	16.00	17.00	17.01		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400						4.00	
5.01	00540						5.01	
5.02	00590						5.02	
5.03	00591						5.03	
5.04	00580						5.04	
5.05	00592						5.05	
7.00	00700						7.00	
8.00	00800						8.00	
9.00	00900						9.00	
10.00	01000						10.00	
11.00	01100						11.00	
13.00	01300						13.00	
14.00	01400	1,000					14.00	
15.00	01500	0	5,889,776				15.00	
16.00	01600	0	0	122,083,158			16.00	
17.00	01700	0	0	0	11,784		17.00	
17.01	01701	0	0	0	0	11,784	17.01	
21.00	02100	0	0	0	0	0	21.00	
22.00	02200	0	0	0	0	0	22.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	0	1,895	18,857,568	7,415	7,415	30.00	
31.00	03100	0	483	3,321,964	1,061	1,061	31.00	
40.00	04000	0	80	7,725,998	2,692	2,692	40.00	
43.00	04300	0	0	1,166,373	616	616	43.00	
46.00	04600	0	0	0	0	0	46.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	0	4,079	9,711,587	0	0	50.00	
52.00	05200	0	57	1,230,395	0	0	52.00	
53.00	05300	0	0	1,487,570	0	0	53.00	
53.01	03950	0	0	0	0	0	53.01	
54.00	05400	0	10,930	991,862	0	0	54.00	
54.01	05401	0	1,547	560,204	0	0	54.01	
57.00	05700	0	596	4,858,128	0	0	57.00	
58.00	05800	0	375	457,789	0	0	58.00	
59.00	05900	0	1,291	9,274,601	0	0	59.00	
60.00	06000	0	393	9,791,617	0	0	60.00	
65.00	06500	0	33,758	9,202,678	0	0	65.00	
66.00	06600	0	552	864,042	0	0	66.00	
67.00	06700	0	0	243,138	0	0	67.00	
68.00	06800	0	0	86,916	0	0	68.00	
69.00	06900	0	0	2,018,650	0	0	69.00	
70.00	07000	0	0	17,288	0	0	70.00	
71.00	07100	1,000	0	12,862,623	0	0	71.00	
71.01	07101	0	0	585,005	0	0	71.01	
72.00	07200	0	0	719,781	0	0	72.00	
73.00	07300	0	2,014,145	22,287,413	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	0	0	0	0	0	90.00	
90.01	09001	0	1,213,594	0	0	0	90.01	
91.00	09100	0	1,808	3,497,611	0	0	91.00	
92.00	09200	0	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	0	10	262,357	0	0	101.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	0	0	0	0	0	113.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)						11,784	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	0	0	0	0	0	190.00	
194.00	07950	0	0	0	0	0	194.00	
194.01	07951	0	2,604,183	0	0	0	194.01	
194.02	07952	0	0	0	0	0	194.02	
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)	72,320	2,076,493	4,435,278	99,184	278,953	202.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	72.320000	0.352559	0.036330	8.416836	23.672183	203.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	16,711	246,073	132,169	291	5,293	204.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0012

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIREMENTS)	PHARMACY (COSTED REQUIREMENTS)	MEDICAL RECORDS & LIBRARY (I/P GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	UTILIZATION REVIEW (PATIENT DAYS)	
		14.00	15.00	16.00	17.00	17.01	
205.00	Unit cost multiplier (Wkst. B, Part II)	16.711000	0.041780	0.001083	0.024695	0.449168	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0012

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

Worksheet B-1
Date/Time Prepared:
5/31/2017 3:55 pm

Cost Center Description	INTERNS & RESIDENTS			
	SERVICES-SALARY & FRINGES A (PATIENT DAYS)	SERVICES-OTHER PRGM COSTS A (PATIENT DAYS)		
	21.00	22.00		
GENERAL SERVICE COST CENTERS				
1.00 00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01 00540	NONPATIENT TELEPHONES			5.01
5.02 00590	DATA PROCESSING			5.02
5.03 00591	PURCHASING RECEIVING AND STORES			5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE			5.04
5.05 00592	OTHER ADMIN & GENERAL			5.05
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
17.01 01701	UTILIZATION REVIEW			17.01
21.00 02100	I&R SERVICES-SALARY & FRINGES A	9,092		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A		9,092	22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000	ADULTS & PEDIATRICS	7,415	7,415	30.00
31.00 03100	INTENSIVE CARE UNIT	1,061	1,061	31.00
40.00 04000	SUBPROVIDER - IPF	0	0	40.00
43.00 04300	NURSERY	616	616	43.00
46.00 04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000	OPERATING ROOM	0	0	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	53.00
53.01 03950	PAIN MANAGEMENT	0	0	53.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 05401	ULTRASOUND	0	0	54.01
57.00 05700	CT SCAN	0	0	57.00
58.00 05800	MRI	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000	LABORATORY	0	0	60.00
65.00 06500	RESPIRATORY THERAPY	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	71.00
71.01 07101	PSYCHIATRY/PSYCHOLOGICAL SERV	0	0	71.01
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000	CLINIC	0	0	90.00
90.01 09001	PROVIDER BASED CLINICS	0	0	90.01
91.00 09100	EMERGENCY	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00 11300	INTEREST EXPENSE			113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	9,092	9,092	118.00
NONREIMBURSABLE COST CENTERS				
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	190.00
194.00 07950	MEALS ON WHEELS	0	0	194.00
194.01 07951	RETAIL PHARMACY	0	0	194.01
194.02 07952	IHAP	0	0	194.02
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)	1,039,299	2,042,461	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	114.309173	224.643753	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0012

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		INTERNS & RESIDENTS		
		SERVICES-SALARY & FRINGES A (PATIENT DAYS)	SERVICES-OTHER PRGM COSTS A (PATIENT DAYS)	
		21.00	22.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	5,534	92,835	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.608667	10.210625	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0012

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

Worksheet C
Part I
Date/Time Prepared:
5/31/2017 3:55 pm

		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		9,767,738	0	9,767,738	30.00
31.00	03100 INTENSIVE CARE UNIT		2,595,877	0	2,595,877	31.00
40.00	04000 SUBPROVIDER - I/PF		2,633,154	0	2,633,154	40.00
43.00	04300 NURSERY		729,289	0	729,289	43.00
46.00	04600 OTHER LONG TERM CARE		0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		6,441,976	0	6,441,976	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		271,753	0	271,753	52.00
53.00	05300 ANESTHESIOLOGY		543,770	0	543,770	53.00
53.01	03950 PAIN MANAGEMENT		0	0	0	53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC		3,890,578	0	3,890,578	54.00
54.01	05401 ULTRASOUND		803,299	0	803,299	54.01
57.00	05700 CT SCAN		953,607	0	953,607	57.00
58.00	05800 MRI		647,638	0	647,638	58.00
59.00	05900 CARDIAC CATHETERIZATION		1,603,139	0	1,603,139	59.00
60.00	06000 LABORATORY		7,310,071	9,624	7,319,695	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,814,370	0	1,814,370	65.00
66.00	06600 PHYSICAL THERAPY	0	3,080,393	0	3,080,393	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	590,033	0	590,033	67.00
68.00	06800 SPEECH PATHOLOGY	0	601,665	0	601,665	68.00
69.00	06900 ELECTROCARDIOLOGY		2,321,866	0	2,321,866	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		499,398	0	499,398	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT		1,873,017	0	1,873,017	71.00
71.01	07101 PSYCHIATRI CE/PSYCHOLOGICAL SERV		568,439	0	568,439	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		5,635,150	0	5,635,150	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		4,257,684	0	4,257,684	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		0	0	0	90.00
90.01	09001 PROVIDER BASED CLINICS		24,857,578	14,354	24,871,932	90.01
91.00	09100 EMERGENCY		6,107,083	773,761	6,880,844	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)		2,490,015	0	2,490,015	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY		1,095,474	0	1,095,474	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		93,984,054	0	93,984,054	200.00
201.00	Less Observation Beds		2,490,015		2,490,015	201.00
202.00	Total (see instructions)		91,494,039	0	91,494,039	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0012		Period: From 01/01/2016 To 12/31/2016		Worksheet C Part I Date/Time Prepared: 5/31/2017 3:55 pm		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	15,548,829		15,548,829				30.00
31.00	03100	INTENSIVE CARE UNIT	3,321,964		3,321,964				31.00
40.00	04000	SUBPROVIDER - IPF	7,725,998		7,725,998				40.00
43.00	04300	NURSERY	1,166,373		1,166,373				43.00
46.00	04600	OTHER LONG TERM CARE	0		0				46.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	9,711,587	28,699,661	38,411,248	0.167711	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,230,395	63,891	1,294,286	0.209964	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	1,487,570	3,405,384	4,892,954	0.111133	0.000000		53.00
53.01	03950	PAIN MANAGEMENT	0	0	0	0.000000	0.000000		53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	991,862	11,557,669	12,549,531	0.310018	0.000000		54.00
54.01	05401	ULTRASOUND	560,204	6,031,908	6,592,112	0.121858	0.000000		54.01
57.00	05700	CT SCAN	4,858,128	24,997,199	29,855,327	0.031941	0.000000		57.00
58.00	05800	MRI	457,789	10,386,106	10,843,895	0.059724	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	9,274,601	20,208,802	29,483,403	0.054374	0.000000		59.00
60.00	06000	LABORATORY	9,791,617	32,066,118	41,857,735	0.174641	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	9,202,678	3,579,230	12,781,908	0.141948	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	864,042	10,098,581	10,962,623	0.280991	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	243,138	1,487,192	1,730,330	0.340994	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	86,916	994,096	1,081,012	0.556576	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	2,018,650	8,200,142	10,218,792	0.227215	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17,288	2,836,457	2,853,745	0.174997	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	12,862,623	18,605,356	31,467,979	0.059521	0.000000		71.00
71.01	07101	PSYCHIATRY/PSYCHOLOGICAL SERV	585,005	365,785	950,790	0.597860	0.000000		71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	719,781	4,977,202	5,696,983	0.989146	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,287,413	21,625,532	43,912,945	0.096957	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0.000000	0.000000		90.00
90.01	09001	PROVIDER BASED CLINICS	46,429	41,012,366	41,058,795	0.605414	0.000000		90.01
91.00	09100	EMERGENCY	3,497,611	18,281,202	21,778,813	0.280414	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	3,308,739	1,157,465	4,466,204	0.557524	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	262,357	956,993	1,219,350				101.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	122,129,587	271,594,337	393,723,924				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	122,129,587	271,594,337	393,723,924				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/31/2017 3:55 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
46.00	04600	OTHER LONG TERM CARE		46.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.167711	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.209964	52.00
53.00	05300	ANESTHESIOLOGY	0.111133	53.00
53.01	03950	PAIN MANAGEMENT	0.000000	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.310018	54.00
54.01	05401	ULTRASOUND	0.121858	54.01
57.00	05700	CT SCAN	0.031941	57.00
58.00	05800	MRI	0.059724	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.054374	59.00
60.00	06000	LABORATORY	0.174871	60.00
65.00	06500	RESPIRATORY THERAPY	0.141948	65.00
66.00	06600	PHYSICAL THERAPY	0.280991	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.340994	67.00
68.00	06800	SPEECH PATHOLOGY	0.556576	68.00
69.00	06900	ELECTROCARDIOLOGY	0.227215	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.174997	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.059521	71.00
71.01	07101	PSYCHIATRI CE/PSYCHOLOGI CAL SERV	0.597860	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.989146	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.096957	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	PROVIDER BASED CLINICS	0.605764	90.01
91.00	09100	EMERGENCY	0.315942	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.557524	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY		101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0012

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

Worksheet C
Part I
Date/Time Prepared:
5/31/2017 3:55 pm

		Title XIX		Hospital		Cost
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		9,767,738	0	9,767,738	30.00
31.00	03100 INTENSIVE CARE UNIT		2,595,877	0	2,595,877	31.00
40.00	04000 SUBPROVIDER - I/PF		2,633,154	0	2,633,154	40.00
43.00	04300 NURSERY		729,289	0	729,289	43.00
46.00	04600 OTHER LONG TERM CARE		0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		6,441,976	0	6,441,976	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		271,753	0	271,753	52.00
53.00	05300 ANESTHESIOLOGY		543,770	0	543,770	53.00
53.01	03950 PAIN MANAGEMENT		0	0	0	53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC		3,890,578	0	3,890,578	54.00
54.01	05401 ULTRASOUND		803,299	0	803,299	54.01
57.00	05700 CT SCAN		953,607	0	953,607	57.00
58.00	05800 MRI		647,638	0	647,638	58.00
59.00	05900 CARDIAC CATHETERIZATION		1,603,139	0	1,603,139	59.00
60.00	06000 LABORATORY		7,310,071	9,624	7,319,695	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,814,370	0	1,814,370	65.00
66.00	06600 PHYSICAL THERAPY	0	3,080,393	0	3,080,393	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	590,033	0	590,033	67.00
68.00	06800 SPEECH PATHOLOGY	0	601,665	0	601,665	68.00
69.00	06900 ELECTROCARDIOLOGY		2,321,866	0	2,321,866	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		499,398	0	499,398	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT		1,873,017	0	1,873,017	71.00
71.01	07101 PSYCHIATRIC/PSYCHOLOGICAL SERV		568,439	0	568,439	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		5,635,150	0	5,635,150	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		4,257,684	0	4,257,684	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		0	0	0	90.00
90.01	09001 PROVIDER BASED CLINICS		24,857,578	14,354	24,871,932	90.01
91.00	09100 EMERGENCY		6,107,083	773,761	6,880,844	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)		2,490,015	0	2,490,015	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY		1,095,474	0	1,095,474	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		93,984,054	0	93,984,054	200.00
201.00	Less Observation Beds		2,490,015		2,490,015	201.00
202.00	Total (see instructions)		91,494,039	0	91,494,039	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0012		Period: From 01/01/2016 To 12/31/2016		Worksheet C Part I Date/Time Prepared: 5/31/2017 3:55 pm	
			Title XIX		Hospital		Cost	
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	15,548,829		15,548,829			30.00
31.00	03100	INTENSIVE CARE UNIT	3,321,964		3,321,964			31.00
40.00	04000	SUBPROVIDER - IPF	7,725,998		7,725,998			40.00
43.00	04300	NURSERY	1,166,373		1,166,373			43.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,711,587	28,699,661	38,411,248	0.167711	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,230,395	63,891	1,294,286	0.209964	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,487,570	3,405,384	4,892,954	0.111133	0.000000	53.00
53.01	03950	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	991,862	11,557,669	12,549,531	0.310018	0.000000	54.00
54.01	05401	ULTRASOUND	560,204	6,031,908	6,592,112	0.121858	0.000000	54.01
57.00	05700	CT SCAN	4,858,128	24,997,199	29,855,327	0.031941	0.000000	57.00
58.00	05800	MRI	457,789	10,386,106	10,843,895	0.059724	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,274,601	20,208,802	29,483,403	0.054374	0.000000	59.00
60.00	06000	LABORATORY	9,791,617	32,066,118	41,857,735	0.174641	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	9,202,678	3,579,230	12,781,908	0.141948	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	864,042	10,098,581	10,962,623	0.280991	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	243,138	1,487,192	1,730,330	0.340994	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	86,916	994,096	1,081,012	0.556576	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,018,650	8,200,142	10,218,792	0.227215	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17,288	2,836,457	2,853,745	0.174997	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	12,862,623	18,605,356	31,467,979	0.059521	0.000000	71.00
71.01	07101	PSYCHIATRY/PSYCHOLOGICAL SERV	585,005	365,785	950,790	0.597860	0.000000	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	719,781	4,977,202	5,696,983	0.989146	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,287,413	21,625,532	43,912,945	0.096957	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	PROVIDER BASED CLINICS	46,429	41,012,366	41,058,795	0.605414	0.000000	90.01
91.00	09100	EMERGENCY	3,497,611	18,281,202	21,778,813	0.280414	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	3,308,739	1,157,465	4,466,204	0.557524	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	262,357	956,993	1,219,350			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	122,129,587	271,594,337	393,723,924			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	122,129,587	271,594,337	393,723,924			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/31/2017 3:55 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
46.00	04600	OTHER LONG TERM CARE		46.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
53.01	03950	PAIN MANAGEMENT	0.000000	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	71.00
71.01	07101	PSYCHIATRY/PSYCHOLOGICAL SERV	0.000000	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	PROVIDER BASED CLINICS	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY		101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0012		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part I Date/Time Prepared: 5/31/2017 3:55 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	960,820	0	960,820	9,952	96.55	30.00
31.00	INTENSIVE CARE UNIT	146,913	0	146,913	1,061	138.47	31.00
40.00	SUBPROVIDER - IPF	157,308	0	157,308	2,692	58.44	40.00
43.00	NURSERY	19,774		19,774	616	32.10	43.00
200.00	Total (lines 30-199)	1,284,815		1,284,815	14,321		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	3,640	351,442				
31.00	INTENSIVE CARE UNIT	179	24,786				
40.00	SUBPROVIDER - IPF	784	45,817				
43.00	NURSERY	0	0				
200.00	Total (lines 30-199)	4,603	422,045				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Prepared: 5/31/2017 3:55 pm
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Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,242,137	38,411,248	0.032338	3,660,767	118,382	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,840	1,294,286	0.021510	3,501	75	52.00
53.00	05300	ANESTHESIOLOGY	30,776	4,892,954	0.006290	536,808	3,377	53.00
53.01	03950	PAIN MANAGEMENT	0	0	0.000000	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	266,765	12,549,531	0.021257	571,744	12,154	54.00
54.01	05401	ULTRASOUND	77,311	6,592,112	0.011728	132,406	1,553	54.01
57.00	05700	CT SCAN	32,449	29,855,327	0.001087	2,408,086	2,618	57.00
58.00	05800	MRI	28,155	10,843,895	0.002596	220,645	573	58.00
59.00	05900	CARDIAC CATHETERIZATION	139,460	29,483,403	0.004730	3,433,317	16,240	59.00
60.00	06000	LABORATORY	401,047	41,857,735	0.009581	4,853,526	46,502	60.00
65.00	06500	RESPIRATORY THERAPY	108,149	12,781,908	0.008461	5,168,362	43,730	65.00
66.00	06600	PHYSICAL THERAPY	230,958	10,962,623	0.021068	503,848	10,615	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,133	1,730,330	0.002389	142,715	341	67.00
68.00	06800	SPEECH PATHOLOGY	37,373	1,081,012	0.034572	60,904	2,106	68.00
69.00	06900	ELECTROCARDIOLOGY	333,808	10,218,792	0.032666	2,012,122	65,728	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	41,686	2,853,745	0.014607	11,738	171	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	144,143	31,467,979	0.004581	7,118,222	32,609	71.00
71.01	07101	PSYCHIATRY/PSYCHOLOGICAL SERV	56,931	950,790	0.059878	113	7	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,540	5,696,983	0.002903	719,781	2,090	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	137,961	43,912,945	0.003142	9,877,242	31,034	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	PROVIDER BASED CLINICS	2,236,491	41,058,795	0.054470	41,696	2,271	90.01
91.00	09100	EMERGENCY	334,578	21,778,813	0.015363	2,002,497	30,764	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	244,935	4,466,204	0.054842	718,681	39,414	92.00
200.00		Total (lines 50-199)	6,173,626	364,741,410		44,198,721	462,354	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0012		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part III Date/Time Prepared: 5/31/2017 3:55 pm	
Cost Center Description			Title XVIII		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
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	9,952	0.00	3,640	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,061	0.00	179	0		31.00
40.00	04000	SUBPROVIDER - IPF	2,692	0.00	784	0		40.00
43.00	04300	NURSERY	616	0.00	0	0		43.00
200.00		Total (lines 30-199)	14,321		4,603	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/31/2017 3:55 pm
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Cost Center Description		Title XVIII				Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
53.01	03950	PAIN MANAGEMENT	0	0	0	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
71.01	07101	PSYCHIATRY/PSYCHOLOGICAL SERV	0	0	0	0	0	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINICS	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	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: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/31/2017 3:55 pm
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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 Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	PPS
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	38,411,248	0.000000	0.000000	3,660,767	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,294,286	0.000000	0.000000	3,501	52.00
53.00	05300 ANESTHESIOLOGY	0	4,892,954	0.000000	0.000000	536,808	53.00
53.01	03950 PAIN MANAGEMENT	0	0	0.000000	0.000000	0	53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	12,549,531	0.000000	0.000000	571,744	54.00
54.01	05401 ULTRASOUND	0	6,592,112	0.000000	0.000000	132,406	54.01
57.00	05700 CT SCAN	0	29,855,327	0.000000	0.000000	2,408,086	57.00
58.00	05800 MRI	0	10,843,895	0.000000	0.000000	220,645	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	29,483,403	0.000000	0.000000	3,433,317	59.00
60.00	06000 LABORATORY	0	41,857,735	0.000000	0.000000	4,853,526	60.00
65.00	06500 RESPIRATORY THERAPY	0	12,781,908	0.000000	0.000000	5,168,362	65.00
66.00	06600 PHYSICAL THERAPY	0	10,962,623	0.000000	0.000000	503,848	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,730,330	0.000000	0.000000	142,715	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,081,012	0.000000	0.000000	60,904	68.00
69.00	06900 ELECTROCARDIOLOGY	0	10,218,792	0.000000	0.000000	2,012,122	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,853,745	0.000000	0.000000	11,738	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	31,467,979	0.000000	0.000000	7,118,222	71.00
71.01	07101 PSYCHIATRY/PSYCHOLOGICAL SERV	0	950,790	0.000000	0.000000	113	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	5,696,983	0.000000	0.000000	719,781	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	43,912,945	0.000000	0.000000	9,877,242	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001 PROVIDER BASED CLINICS	0	41,058,795	0.000000	0.000000	41,696	90.01
91.00	09100 EMERGENCY	0	21,778,813	0.000000	0.000000	2,002,497	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	4,466,204	0.000000	0.000000	718,681	92.00
200.00	Total (lines 50-199)	0	364,741,410			44,198,721	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/31/2017 3:55 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII					
Hospital					
PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	7,147,456	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	654,896	0	53.00
53.01	03950 PAIN MANAGEMENT	0	0	0	53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	3,627,902	0	54.00
54.01	05401 ULTRASOUND	0	589,337	0	54.01
57.00	05700 CT SCAN	0	7,905,206	0	57.00
58.00	05800 MRI	0	2,833,758	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	8,800,344	0	59.00
60.00	06000 LABORATORY	0	4,400,715	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,831,526	0	65.00
66.00	06600 PHYSICAL THERAPY	0	48,278	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	9,126	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	73,940	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	4,193,454	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	560,293	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	5,699,189	0	71.00
71.01	07101 PSYCHIATRY/PSYCHOLOGICAL SERV	0	41,375	0	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2,171,252	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6,845,014	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 PROVIDER BASED CLINICS	0	3,257,922	0	90.01
91.00	09100 EMERGENCY	0	4,228,988	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	1,157,465	0	92.00
200.00	Total (lines 50-199)	0	66,077,436	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/31/2017 3:55 pm
		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	0.167711	7,147,456	0	0	1,198,707	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.209964	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.111133	654,896	0	0	72,781	53.00
53.01	03950 PAIN MANAGEMENT	0.000000	0	0	0	0	53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.310018	3,627,902	0	0	1,124,715	54.00
54.01	05401 ULTRASOUND	0.121858	589,337	0	0	71,815	54.01
57.00	05700 CT SCAN	0.031941	7,905,206	0	0	252,500	57.00
58.00	05800 MRI	0.059724	2,833,758	0	0	169,243	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.054374	8,800,344	0	0	478,510	59.00
60.00	06000 LABORATORY	0.174641	4,400,715	88	0	768,545	60.00
65.00	06500 RESPIRATORY THERAPY	0.141948	1,831,526	0	0	259,981	65.00
66.00	06600 PHYSICAL THERAPY	0.280991	48,278	0	0	13,566	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.340994	9,126	0	0	3,112	67.00
68.00	06800 SPEECH PATHOLOGY	0.556576	73,940	0	0	41,153	68.00
69.00	06900 ELECTROCARDIOLOGY	0.227215	4,193,454	0	0	952,816	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.174997	560,293	0	0	98,050	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.059521	5,699,189	0	0	339,221	71.00
71.01	07101 PSYCHIATRIC/PSYCHOLOGICAL SERV	0.597860	41,375	0	0	24,736	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.989146	2,171,252	0	0	2,147,685	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.096957	6,845,014	8,288	190,231	663,672	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	09001 PROVIDER BASED CLINICS	0.605414	3,257,922	105	0	1,972,392	90.01
91.00	09100 EMERGENCY	0.280414	4,228,988	0	682	1,185,867	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.557524	1,157,465	0	0	645,315	92.00
200.00	Subtotal (see instructions)		66,077,436	8,481	190,913	12,484,382	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (Line 200 +/- Line 201)		66,077,436	8,481	190,913	12,484,382	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 5/31/2017 3:55 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
53.01 03950 PAIN MANAGEMENT	0	0		53.01
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 05401 ULTRASOUND	0	0		54.01
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	15	0		60.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
71.01 07101 PSYCHIATRIC/PSYCHOLOGICAL SERV	0	0		71.01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	804	18,444		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 PROVIDER BASED CLINICS	64	0		90.01
91.00 09100 EMERGENCY	0	191		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	0		92.00
200.00 Subtotal (see instructions)	883	18,635		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	883	18,635		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 14-0012 Component CCN: 14-S012		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part II Date/Time Prepared: 5/31/2017 3:55 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,242,137	38,411,248	0.032338	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,840	1,294,286	0.021510	0	0	52.00
53.00	05300	ANESTHESIOLOGY	30,776	4,892,954	0.006290	0	0	53.00
53.01	03950	PAIN MANAGEMENT	0	0	0.000000	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	266,765	12,549,531	0.021257	4,932	105	54.00
54.01	05401	ULTRASOUND	77,311	6,592,112	0.011728	1,769	21	54.01
57.00	05700	CT SCAN	32,449	29,855,327	0.001087	32,052	35	57.00
58.00	05800	MRI	28,155	10,843,895	0.002596	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	139,460	29,483,403	0.004730	1,047	5	59.00
60.00	06000	LABORATORY	401,047	41,857,735	0.009581	277,390	2,658	60.00
65.00	06500	RESPIRATORY THERAPY	108,149	12,781,908	0.008461	99,820	845	65.00
66.00	06600	PHYSICAL THERAPY	230,958	10,962,623	0.021068	4,855	102	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,133	1,730,330	0.002389	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	37,373	1,081,012	0.034572	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	333,808	10,218,792	0.032666	6,528	213	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	41,686	2,853,745	0.014607	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	144,143	31,467,979	0.004581	2,959	14	71.00
71.01	07101	PSYCHIATRY/PSYCHOLOGICAL SERV	56,931	950,790	0.059878	157,672	9,441	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,540	5,696,983	0.002903	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	137,961	43,912,945	0.003142	466,129	1,465	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	PROVIDER BASED CLINICS	2,236,491	41,058,795	0.054470	4,733	258	90.01
91.00	09100	EMERGENCY	334,578	21,778,813	0.015363	130,453	2,004	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	4,466,204	0.000000	0	0	92.00
200.00		Total (lines 50-199)	5,928,691	364,741,410		1,190,339	17,166	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0012 Component CCN: 14-S012	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/31/2017 3:55 pm
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Title XVIII		Subprovider - IPF	PPS
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Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
53.01	03950	PAIN MANAGEMENT	0	0	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
71.01	07101	PSYCHIATRY/PSYCHOLOGICAL SERV	0	0	0	0	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINICS	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0012 Component CCN: 14-S012	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/31/2017 3:55 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description			Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	38,411,248	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,294,286	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	4,892,954	0.000000	0.000000	0	53.00
53.01	03950	PAIN MANAGEMENT	0	0	0.000000	0.000000	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,549,531	0.000000	0.000000	4,932	54.00
54.01	05401	ULTRASOUND	0	6,592,112	0.000000	0.000000	1,769	54.01
57.00	05700	CT SCAN	0	29,855,327	0.000000	0.000000	32,052	57.00
58.00	05800	MRI	0	10,843,895	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	29,483,403	0.000000	0.000000	1,047	59.00
60.00	06000	LABORATORY	0	41,857,735	0.000000	0.000000	277,390	60.00
65.00	06500	RESPIRATORY THERAPY	0	12,781,908	0.000000	0.000000	99,820	65.00
66.00	06600	PHYSICAL THERAPY	0	10,962,623	0.000000	0.000000	4,855	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,730,330	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,081,012	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,218,792	0.000000	0.000000	6,528	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,853,745	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	31,467,979	0.000000	0.000000	2,959	71.00
71.01	07101	PSYCHIATRY/PSYCHOLOGICAL SERV	0	950,790	0.000000	0.000000	157,672	71.01
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,696,983	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	43,912,945	0.000000	0.000000	466,129	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	PROVIDER BASED CLINICS	0	41,058,795	0.000000	0.000000	4,733	90.01
91.00	09100	EMERGENCY	0	21,778,813	0.000000	0.000000	130,453	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	4,466,204	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	364,741,410			1,190,339	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0012 Component CCN: 14-S012	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 5/31/2017 3:55 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
53.01	03950 PAIN MANAGEMENT	0	0	0	53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	05401 ULTRASOUND	0	0	0	54.01
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MRI	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	71.00
71.01	07101 PSYCHIATRY/PSYCHOLOGICAL SERV	0	0	0	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 PROVIDER BASED CLINICS	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/31/2017 3:55 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		9,952	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		9,952	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)		7,415	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)		3,640	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)		9,767,738	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)		9,767,738	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)		9,767,738	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)		981.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,572,587	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)		3,572,587	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/31/2017 3:55 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	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	2,595,877	1,061	2,446.63	179	437,947	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)					6,562,266	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					10,572,800	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)					376,228	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					462,354	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					838,582	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					9,734,218	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)					2,537	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					981.48	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,490,015	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0012		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/31/2017 3:55 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	960,820	9,767,738	0.098367	2,490,015	244,935	90.00
91.00	Nursing School cost	0	9,767,738	0.000000	2,490,015	0	91.00
92.00	Allied health cost	0	9,767,738	0.000000	2,490,015	0	92.00
93.00	All other Medical Education	0	9,767,738	0.000000	2,490,015	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0012 Component CCN: 14-S012	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/31/2017 3:55 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,692	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,692	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)		2,692	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)		784	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)		2,633,154	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)		2,633,154	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)		2,633,154	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)		978.14	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		766,862	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)		766,862	41.00

COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1
					Component CCN: 14-S012		Date/Time Prepared: 5/31/2017 3:55 pm
					Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
						1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						252,068	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						1,018,930	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)						45,817	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						17,166	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						62,983	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						955,947	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)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0012 Component CCN: 14-S012		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 5/31/2017 3:55 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	157,308	2,633,154	0.059741	0	0	90.00
91.00	Nursing School cost	0	2,633,154	0.000000	0	0	91.00
92.00	Allied health cost	0	2,633,154	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,633,154	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/31/2017 3:55 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		6,066,849		30.00
31.00	03100 INTENSIVE CARE UNIT		778,829		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.167711	3,660,767	613,951	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.209964	3,501	735	52.00
53.00	05300 ANESTHESIOLOGY	0.111133	536,808	59,657	53.00
53.01	03950 PAIN MANAGEMENT	0.000000	0	0	53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.310018	571,744	177,251	54.00
54.01	05401 ULTRASOUND	0.121858	132,406	16,135	54.01
57.00	05700 CT SCAN	0.031941	2,408,086	76,917	57.00
58.00	05800 MRI	0.059724	220,645	13,178	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.054374	3,433,317	186,683	59.00
60.00	06000 LABORATORY	0.174871	4,853,526	848,741	60.00
65.00	06500 RESPIRATORY THERAPY	0.141948	5,168,362	733,639	65.00
66.00	06600 PHYSICAL THERAPY	0.280991	503,848	141,577	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.340994	142,715	48,665	67.00
68.00	06800 SPEECH PATHOLOGY	0.556576	60,904	33,898	68.00
69.00	06900 ELECTROCARDIOLOGY	0.227215	2,012,122	457,184	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.174997	11,738	2,054	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.059521	7,118,222	423,684	71.00
71.01	07101 PSYCHIATRIC/PSYCHOLOGICAL SERV	0.597860	113	68	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.989146	719,781	711,968	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.096957	9,877,242	957,668	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 PROVIDER BASED CLINICS	0.605764	41,696	25,258	90.01
91.00	09100 EMERGENCY	0.315942	2,002,497	632,673	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.557524	718,681	400,682	92.00
200.00	Total (sum of lines 50-94 and 96-98)		44,198,721	6,562,266	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		44,198,721		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0012 Component CCN: 14-S012	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 5/31/2017 3:55 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		1,940,380	40.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.167711	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.209964	0	52.00
53.00	05300 ANESTHESIOLOGY	0.111133	0	53.00
53.01	03950 PAIN MANAGEMENT	0.000000	0	53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.310018	4,932	54.00
54.01	05401 ULTRASOUND	0.121858	1,769	54.01
57.00	05700 CT SCAN	0.031941	32,052	57.00
58.00	05800 MRI	0.059724	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.054374	1,047	59.00
60.00	06000 LABORATORY	0.174871	277,390	60.00
65.00	06500 RESPIRATORY THERAPY	0.141948	99,820	65.00
66.00	06600 PHYSICAL THERAPY	0.280991	4,855	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.340994	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.556576	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.227215	6,528	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.174997	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.059521	2,959	71.00
71.01	07101 PSYCHIATRIC/PSYCHOLOGICAL SERV	0.597860	157,672	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.989146	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.096957	466,129	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000	0	90.00
90.01	09001 PROVIDER BASED CLINICS	0.605764	4,733	90.01
91.00	09100 EMERGENCY	0.315942	130,453	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.557524	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,190,339	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)		1,190,339	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/31/2017 3:55 pm
		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)		6,430,270	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,143,423	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)		180,203	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)		59.07	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)		6.00	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)		6.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		3.38	10.00
11.00	FTE count for residents in dental and podiatric programs.		2.89	11.00
12.00	Current year allowable FTE (see instructions)		6.27	12.00
13.00	Total allowable FTE count for the prior year.		6.69	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.		3.90	14.00
15.00	Sum of lines 12 through 14 divided by 3.		5.62	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		5.62	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.095141	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.098670	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.095141	21.00
22.00	IME payment adjustment (see instructions)		433,966	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)		-2.62	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)		433,966	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)		4.54	30.00
31.00	Percentage of Medicaid patient days (see instructions)		26.92	31.00
32.00	Sum of lines 30 and 31		31.46	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00	33.00
34.00	Disproportionate share adjustment (see instructions)		257,211	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/31/2017 3:55 pm	
		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)		0.000079362	0.000069698	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		508,402	416,620	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		380,607	105,011	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		485,618		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)		9,930,691		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)			9,930,691	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			750,249	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).			115,668	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)			10,796,608	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			10,796,608	61.00
62.00	Deductibles billed to program beneficiaries			1,126,832	62.00
63.00	Coinurance billed to program beneficiaries			1,288	63.00
64.00	Allowable bad debts (see instructions)			169,255	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			110,016	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			79,472	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			9,778,504	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)			91,549	70.93
70.94	HRR adjustment amount (see instructions)			-12,456	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 5/31/2017 3:55 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			25,685	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			9,831,912	71.00
71.01	Sequestration adjustment (see instructions)			196,638	71.01
72.00	Interim payments			9,434,380	72.00
73.00	Tentative settlement (for contractor use only)			0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)			200,894	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	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: 14-0012

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/31/2017 3:55 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,430,270	0	6,430,270		6,430,270	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,143,423	0		2,143,423	2,143,423	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	180,203	0	135,152	45,051	180,203	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	0.095141	0.095141	0.095141	0.095141		5.00
6.00	IME payment adjustment (see instructions)	22.00	433,966	0	325,475	108,491	433,966	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	433,966	0	325,475	108,491	433,966	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	257,211	0	192,908	64,303	257,211	11.00
11.01	Uncompensated care payments	36.00	485,618	0	454,370	112,542	566,912	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	9,930,691	0	7,456,881	2,473,810	9,930,691	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	9,930,691	0	7,456,881	2,473,810	9,930,691	15.00
16.00	Payment for inpatient program capital	50.00	750,249	0	-187,563	937,812	750,249	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
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0012

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/31/2017 3:55 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	7,269,318	3,411,622	10,680,940	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	689,487	0	-172,372	861,859	689,487	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	12,360	0	-3,090	15,450	12,360	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	0.0702	0.0702	0.0702	0.0702		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	48,402	0	-12,101	60,503	48,402	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	750,249	0	-187,563	937,812	750,249	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				0.052143	0.066964		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			379,044		379,044	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				228,456	228,456	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/31/2017 3:55 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		19,518	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		12,484,382	2.00
3.00	PPS payments		12,086,047	3.00
4.00	Outlier payment (see instructions)		158,809	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)		19,518	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		199,394	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)		199,394	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)		199,394	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		179,876	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)		19,518	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		12,244,856	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)		2,585,370	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)		9,679,004	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		124,762	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)		9,803,766	30.00
31.00	Primary payer payments		812	31.00
32.00	Subtotal (line 30 minus line 31)		9,802,954	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)		135,818	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		88,282	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		9,891,236	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		9,891,236	40.00
40.01	Sequestration adjustment (see instructions)		197,825	40.01
41.00	Interim payments		9,651,505	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		41,906	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: 14-0012

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

Worksheet E-1
Part I
Date/Time Prepared:
5/31/2017 3:55 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		9,213,130		9,485,876	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		129,506		112,765	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	12/29/2016	155,220	12/29/2016	40,243	3.01	
3.02			0	08/23/2016	12,621	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	08/23/2016	63,476		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)		91,744		52,864	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)		9,434,380		9,651,505	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		200,894		41,906	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		9,635,274		9,693,411	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0012 Component CCN: 14-S012	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part I Date/Time Prepared: 5/31/2017 3:55 pm	
		Title XVIII	Subprovider - IPF	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		675,361		0
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
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)				
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
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)		675,361		0
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)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		32		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		675,393		0
				Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part II Date/Time Prepared: 5/31/2017 3:55 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		2,929	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		3,819	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		0	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		8,476	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		393,723,924	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		4,269,737	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)		268,290	8.00
9.00	Sequestration adjustment amount (see instructions)		5,366	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		262,924	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)		0	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		262,924	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0012 Component CCN: 14-S012	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part II Date/Time Prepared: 5/31/2017 3:55 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			700,642 1.00
2.00	Net IPF PPS Outlier Payments			99,947 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			7,355,191 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			800,589 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			800,589 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			800,589 18.00
19.00	Deductibles			108,192 19.00
20.00	Subtotal (line 18 minus line 19)			692,397 20.00
21.00	Coinsurance			3,220 21.00
22.00	Subtotal (line 20 minus line 21)			689,177 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			689,177 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			689,177 31.00
31.01	Sequestration adjustment (see instructions)			13,784 31.01
32.00	Interim payments			675,361 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			32 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			99,947 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet E-4 Date/Time Prepared: 5/31/2017 3:55 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			6.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			6.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			3.38	6.00
7.00	Enter the lesser of line 5 or line 6			3.38	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	3.38	0.00	3.38	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	3.38	0.00	3.38	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		2.89		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	3.38	2.89		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	3.63	3.06		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	4.84	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	3.95	1.98		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	3.95	1.98		17.00
18.00	Per resident amount	99,093.56	99,093.56		18.00
19.00	Approved amount for resident costs	391,420	196,205	587,625	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			587,625	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	4,603	0		26.00
27.00	Total Inpatient Days (see instructions)	11,250	11,250		27.00
28.00	Ratio of inpatient days to total inpatient days	0.409156	0.000000		28.00
29.00	Program direct GME amount	240,430	0		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		0		30.00
31.00	Net Program direct GME amount			240,430	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet E-4 Date/Time Prepared: 5/31/2017 3:55 pm
		Title XVIII	Hospital	PPS
		1.00		
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		11,591,730	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		11,591,730	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		12,503,900	42.00
43.00	Primary payer payments (see instructions)		812	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		12,503,088	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		24,094,818	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.481088	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.518912	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		240,430	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		115,668	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		124,762	50.00

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

Provider CCN: 14-0012

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

Worksheet G

Date/Time Prepared:
5/31/2017 3:55 pm

		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	11,453,090	0	0	0	1.00
2.00	Temporary investments	3,642,157	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	28,165,092	0	0	0	4.00
5.00	Other receivable	1,522,669	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,447,389	0	0	0	7.00
8.00	Prepaid expenses	1,147,776	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	47,378,173	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,129,972	0	0	0	12.00
13.00	Land improvements	5,393,440	0	0	0	13.00
14.00	Accumulated depreciation	-2,964,034	0	0	0	14.00
15.00	Buildings	47,832,461	0	0	0	15.00
16.00	Accumulated depreciation	-28,518,503	0	0	0	16.00
17.00	Leasehold improvements	19,000	0	0	0	17.00
18.00	Accumulated depreciation	-18,173	0	0	0	18.00
19.00	Fixed equipment	30,590,669	0	0	0	19.00
20.00	Accumulated depreciation	-18,507,950	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	37,238,975	0	0	0	23.00
24.00	Accumulated depreciation	-32,095,126	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	626,896	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	41,727,627	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	687,974	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	26,285,895	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	26,973,869	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	116,079,669	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,644,761	0	0	0	37.00
38.00	Salaries, wages, and fees payable	7,528,857	0	0	0	38.00
39.00	Payroll taxes payable	625,470	0	0	0	39.00
40.00	Notes and loans payable (short term)	13,807,816	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,797,133	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	26,404,037	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	3,483,352	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	18,917,756	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	22,401,108	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	48,805,145	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	67,274,524				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)	67,274,524	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	116,079,669	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0012

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

Worksheet G-1

Date/Time Prepared:
5/31/2017 3:55 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		62,275,086			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		4,999,441				2.00
3.00	Total (sum of line 1 and line 2)		67,274,527			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)		67,274,527			0	11.00
12.00	ROUNDING	3		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)		3			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		67,274,524			0	19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	ROUNDING		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0012

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/31/2017 3:55 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	19,055,610		19,055,610	1.00
2.00	SUBPROVIDER - IPF	8,290,840		8,290,840	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	3,000		3,000	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	27,349,450		27,349,450	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	6,774,004		6,774,004	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	6,774,004		6,774,004	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	34,123,454		34,123,454	17.00
18.00	Ancillary services	83,615,878	212,195,855	295,811,733	18.00
19.00	Outpatient services	3,493,578	98,313,636	101,807,214	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		1,219,350	1,219,350	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	121,232,910	311,728,841	432,961,751	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		123,236,069		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)		123,236,069		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0012

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

Worksheet G-3

Date/Time Prepared:
5/31/2017 3:55 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	432,961,751	1.00
2.00	Less contractual allowances and discounts on patients' accounts	308,055,391	2.00
3.00	Net patient revenues (line 1 minus line 2)	124,906,360	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	123,236,069	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,670,291	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	441,062	6.00
7.00	Income from investments	481,412	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	28,645	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	57,343	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	457,464	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	10,158	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	55,648	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	8,113	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	351,980	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS REVENUE	15,937	24.00
24.01	MEANINGFUL USE PAYMENTS	89,529	24.01
24.02	RETAIL PHARMACY REVENUE	1,137,069	24.02
24.03	GAIN/LOSS ON DISPOSAL OF ASSETS	118,228	24.03
24.04	RHS PARTNERSHIP REVENUE	76,562	24.04
25.00	Total other income (sum of lines 6-24)	3,329,150	25.00
26.00	Total (line 5 plus line 25)	4,999,441	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)	4,999,441	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0012

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

Worksheet H

HHA CCN: 14-7131

Date/Time Prepared: 5/31/2017 3:55 pm

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		0	0	0	0	0	4.00
5.00	181,666	13,119	0	11,342	30,857	236,984	5.00
HHA REIMBURSABLE SERVICES							
6.00	271,926	19,637	5,759	0	0	297,322	6.00
7.00	0	0	5,118	0	0	5,118	7.00
8.00	0	0	589	0	0	589	8.00
9.00	0	0	110	0	0	110	9.00
10.00	0	0	0	0	0	0	10.00
11.00	21,547	1,556	1,116	0	0	24,219	11.00
12.00	0	0	0	0	20,974	20,974	12.00
13.00	0	0	0	0	0	0	13.00
14.00	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	0	0	0	0	0	0	23.00
23.50	0	0	0	0	0	0	23.50
24.00	475,139	34,312	12,692	11,342	51,831	585,316	24.00
	Reclassified	Reclassified	Adjustments	Net Expenses			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	0	0	0	0			1.00
2.00	0	0	0	0			2.00
3.00	0	0	0	0			3.00
4.00	5,384	5,384	0	5,384			4.00
5.00	0	236,984	0	236,984			5.00
HHA REIMBURSABLE SERVICES							
6.00	0	297,322	0	297,322			6.00
7.00	0	5,118	0	5,118			7.00
8.00	0	589	0	589			8.00
9.00	0	110	0	110			9.00
10.00	0	0	0	0			10.00
11.00	0	24,219	0	24,219			11.00
12.00	-12,571	8,403	0	8,403			12.00
13.00	0	0	0	0			13.00
14.00	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	0	0	0			22.00
23.00	0	0	0	0			23.00
23.50	0	0	0	0			23.50
24.00	-7,187	578,129	0	578,129			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 14-0012 HHA CCN: 14-7131		Period: From 01/01/2016 To 12/31/2016		Worksheet H-1 Part I Date/Time Prepared: 5/31/2017 3:55 pm	
				Home Health Agency I		PPS	
	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bldgs & Fixtures	Movable Equipment				
	0	1.00	2.00	3.00	4.00	4A.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	0		0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	5,384	0	0	0	5,384	4.00
5.00	Administrative and General	236,984	0	0	0	5,384	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	297,322	0	0	0	0	6.00
7.00	Physical Therapy	5,118	0	0	0	0	7.00
8.00	Occupational Therapy	589	0	0	0	0	8.00
9.00	Speech Pathology	110	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	24,219	0	0	0	0	11.00
12.00	Supplies (see instructions)	8,403	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	578,129	0	0	0	5,384	24.00
		Administrative & General	Total (cols. 4A + 5)				
		5.00	6.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures						1.00
2.00	Capital Related - Movable Equipment						2.00
3.00	Plant Operation & Maintenance						3.00
4.00	Transportation						4.00
5.00	Administrative and General	242,368					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	214,622	511,944				6.00
7.00	Physical Therapy	3,694	8,812				7.00
8.00	Occupational Therapy	425	1,014				8.00
9.00	Speech Pathology	79	189				9.00
10.00	Medical Social Services	0	0				10.00
11.00	Home Health Aide	17,482	41,701				11.00
12.00	Supplies (see instructions)	6,066	14,469				12.00
13.00	Drugs	0	0				13.00
14.00	DME	0	0				14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	All Others (specify)	0	0				23.00
23.50	Telemedicine	0	0				23.50
24.00	Total (sum of lines 1-23)		578,129				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0012

Period: From 01/01/2016

Worksheet H-1

HHA CCN: 14-7131

To 12/31/2016

Part II
Date/Time Prepared:
5/31/2017 3:55 pm

Home Health Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	100		4.00
5.00	Administrative and General	0	0	0	100	-242,368	335,761
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	297,322
7.00	Physical Therapy	0	0	0	0	0	5,118
8.00	Occupational Therapy	0	0	0	0	0	589
9.00	Speech Pathology	0	0	0	0	0	110
10.00	Medical Social Services	0	0	0	0	0	0
11.00	Home Health Aide	0	0	0	0	0	24,219
12.00	Supplies (see instructions)	0	0	0	0	0	8,403
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	100	-242,368	335,761
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	5,384		242,368
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	53.840000		0.721847

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet H-2 Part I Date/Time Prepared: 5/31/2017 3:55 pm
		HHA CCN: 14-7131	Home Health Agency I	PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	DATA PROCESSING	
		BLDG & FIXT	MVBLE EQUIP				
		1.00	2.00				
1.00 Administrative and General	0	14,914	433	50,971	2,952	36,912	1.00
2.00 Skilled Nursing Care	511,944	18,592	0	76,297	3,542	43,063	2.00
3.00 Physical Therapy	8,812	0	0	0	0	0	3.00
4.00 Occupational Therapy	1,014	0	0	0	0	0	4.00
5.00 Speech Pathology	189	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	41,701	3,627	0	6,046	590	6,152	7.00
8.00 Supplies (see instructions)	14,469	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	578,129	37,133	433	133,314	7,084	86,127	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

Cost Center Description	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
	5.03	5.04	5A.04	5.05	7.00	8.00	
	1.00 Administrative and General	3,319	0	109,501	10,005	28,396	0
2.00 Skilled Nursing Care	0	11,008	664,446	60,706	35,398	0	2.00
3.00 Physical Therapy	0	0	8,812	805	0	0	3.00
4.00 Occupational Therapy	0	0	1,014	93	0	0	4.00
5.00 Speech Pathology	0	0	189	17	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	58,116	5,310	6,906	0	7.00
8.00 Supplies (see instructions)	0	0	14,469	1,322	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	3,319	11,008	856,547	78,258	70,700	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.000000				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0012

Period: From 01/01/2016

Worksheet H-2

HHA CCN: 14-7131

To 12/31/2016

Part I
Date/Time Prepared:
5/31/2017 3:55 pm

Home Health Agency I

PPS

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	4,721	0	7,149	52,208	0	2	1.00
2.00	Skilled Nursing Care	6,070	0	8,937	0	0	2	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	1,349	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	12,140	0	16,086	52,208	0	4	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	UTILIZATION REVIEW	INTERNS & RESIDENTS		Subtotal	
		16.00	17.00	17.01	SERVICES-SALARIES & FRINGES A	SERVICES-OTHER PRGM COSTS A		
1.00	Administrative and General	9,531	0	0	0	0	221,513	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	775,559	2.00
3.00	Physical Therapy	0	0	0	0	0	9,617	3.00
4.00	Occupational Therapy	0	0	0	0	0	1,107	4.00
5.00	Speech Pathology	0	0	0	0	0	206	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	71,681	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	15,791	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	9,531	0	0	0	0	1,095,474	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet H-2 Part I Date/Time Prepared: 5/31/2017 3:55 pm
		HHA CCN: 14-7131	Home Health Agency I	PPS

Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
	25.00	26.00	27.00	28.00		
1.00 Administrative and General	0	221,513				1.00
2.00 Skilled Nursing Care	0	775,559	196,572	972,131		2.00
3.00 Physical Therapy	0	9,617	2,438	12,055		3.00
4.00 Occupational Therapy	0	1,107	281	1,388		4.00
5.00 Speech Pathology	0	206	52	258		5.00
6.00 Medical Social Services	0	0	0	0		6.00
7.00 Home Health Aide	0	71,681	18,168	89,849		7.00
8.00 Supplies (see instructions)	0	15,791	4,002	19,793		8.00
9.00 Drugs	0	0	0	0		9.00
10.00 DME	0	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0	0		13.00
14.00 Clinic	0	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0	0		15.00
16.00 Day Care Program	0	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0	0		17.00
18.00 Homemaker Service	0	0	0	0		18.00
19.00 All Others (specify)	0	0	0	0		19.00
19.50 Telemedicine	0	0	0	0		19.50
20.00 Total (sum of lines 1-19) (2)	0	1,095,474	221,513	1,095,474		20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.253459			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0012

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

Worksheet H-2 Part II

HHA CCN: 14-7131

Date/Time Prepared: 5/31/2017 3:55 pm

Home Health Agency I

PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (TELEPHONES)	DATA PROCESSING (NUMBER OF MACHINES)	PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	1,472	407	181,666	5	6	23,242	1.00
2.00 Skilled Nursing Care	1,835	0	271,928	6	7	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	358	0	21,547	1	1	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	3,665	407	475,141	12	14	23,242	20.00
21.00 Total cost to be allocated	37,133	433	133,314	7,084	86,127	3,319	21.00
22.00 Unit cost multiplier	10.131787	1.063882	0.280578	590.333333	6,151.928571	0.142802	22.00
Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
	5.04	5A.05	5.05	7.00	8.00	9.00	
1.00 Administrative and General	0	0	109,501	1,472	0	7	1.00
2.00 Skilled Nursing Care	1,219,350	0	664,446	1,835	0	9	2.00
3.00 Physical Therapy	0	0	8,812	0	0	0	3.00
4.00 Occupational Therapy	0	0	1,014	0	0	0	4.00
5.00 Speech Pathology	0	0	189	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	58,116	358	0	2	7.00
8.00 Supplies (see instructions)	0	0	14,469	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	1,219,350		856,547	3,665	0	18	20.00
21.00 Total cost to be allocated	11,008		78,258	70,700	0	12,140	21.00
22.00 Unit cost multiplier	0.009028		0.091365	19.290587	0.000000	674.444444	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 14-0012 HHA CCN: 14-7131	Period: From 01/01/2016 To 12/31/2016	Worksheet H-2 Part II Date/Time Prepared: 5/31/2017 3:55 pm
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Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIREMENTS)	PHARMACY (COSTED REQUIREMENTS)	MEDICAL RECORDS & LIBRARY (I/P GROSS CHARGES)	
	10.00	11.00	13.00	14.00	15.00	16.00	
1.00 Administrative and General	0	4	18,730	0	4	262,357	1.00
2.00 Skilled Nursing Care	0	5	0	0	5	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	1	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	0	9	18,730	0	10	262,357	20.00
21.00 Total cost to be allocated	0	16,086	52,208	0	4	9,531	21.00
22.00 Unit cost multiplier	0.000000	1,787.333333	2.787400	0.000000	0.400000	0.036328	22.00

Cost Center Description	INTERNS & RESIDENTS				
	SOCIAL SERVICE (PATIENT DAYS)	UTILIZATION REVIEW (PATIENT DAYS)	SERVICES-SALARY & FRINGES (PATIENT DAYS)	SERVICES-OTHER PRGM COSTS (PATIENT DAYS)	
	17.00	17.01	21.00	22.00	
1.00 Administrative and General	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	9.00
10.00 DME	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	0	0	0	0	20.00
21.00 Total cost to be allocated	0	0	0	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 14-0012 HHA CCN: 14-7131		Period: From 01/01/2016 To 12/31/2016		Worksheet H-3 Part I Date/Time Prepared: 5/31/2017 3:55 pm	
				Title XVIII		Home Health Agency I		PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 + col. 4)		
		0	1.00	2.00	3.00	4.00	5.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	2.00	972,131		972,131	2,983	325.89		1.00
2.00	Physical Therapy	3.00	12,055	304,593	316,648	2,651	119.44		2.00
3.00	Occupational Therapy	4.00	1,388	40,061	41,449	305	135.90		3.00
4.00	Speech Pathology	5.00	258	11,279	11,537	57	202.40		4.00
5.00	Medical Social Services	6.00	0		0	0	0.00		5.00
6.00	Home Health Aide	7.00	89,849		89,849	578	155.45		6.00
7.00	Total (sum of lines 1-6)		1,075,681	355,933	1,431,614	6,574			7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits				
					Part B				
					Not Subject to Deductibles & Coinsurance		Subject to Deductibles		
		0	1.00	2.00	3.00		4.00		5.00
Limitation Cost Computation									
8.00	Skilled Nursing Care		99914	0	1,067				8.00
9.00	Physical Therapy		99914	0	1,148				9.00
10.00	Occupational Therapy		99914	0	97				10.00
11.00	Speech Pathology		99914	0	17				11.00
12.00	Medical Social Services		99914	0	0				12.00
13.00	Home Health Aide		99914	0	198				13.00
14.00	Total (sum of lines 8-13)			0	2,527				14.00
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 + col. 4)		
		0	1.00	2.00	3.00	4.00	5.00		
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	8.00	19,793	3,332	23,125	55,984	0.413064		15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000		16.00
Cost Center Description		Part A	Program Visits		Cost of Services				
			Part B			Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		6.00	7.00	8.00	9.00	10.00	11.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	0	1,067		0	347,725			1.00
2.00	Physical Therapy	0	1,148		0	137,117			2.00
3.00	Occupational Therapy	0	97		0	13,182			3.00
4.00	Speech Pathology	0	17		0	3,441			4.00
5.00	Medical Social Services	0	0		0	0			5.00
6.00	Home Health Aide	0	198		0	30,779			6.00
7.00	Total (sum of lines 1-6)	0	2,527		0	532,244			7.00
Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care								8.00
9.00	Physical Therapy								9.00
10.00	Occupational Therapy								10.00
11.00	Speech Pathology								11.00
12.00	Medical Social Services								12.00
13.00	Home Health Aide								13.00
14.00	Total (sum of lines 8-13)								14.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet H-3 Part I Date/Time Prepared: 5/31/2017 3:55 pm	
				HHA CCN: 14-7131			
				Title XVIII	Home Health Agency I	PPS	
Cost Center Description	Program Covered Charges			Cost of Services			
	Part A	Part B					
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	6.00	7.00	8.00	9.00	10.00	11.00	
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	86,744	0	0	
16.00	Cost of Drugs		0	0		35,831	
Cost Center Description							
		Total Program Cost (sum of col.s. 9-10)					
		12.00					
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	347,725					1.00
2.00	Physical Therapy	137,117					2.00
3.00	Occupational Therapy	13,182					3.00
4.00	Speech Pathology	3,441					4.00
5.00	Medical Social Services	0					5.00
6.00	Home Health Aide	30,779					6.00
7.00	Total (sum of lines 1-6)	532,244					7.00
Cost Center Description							
		12.00					
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0012
HHA CCN: 14-7131

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

Worksheet H-3
Part II
Date/Time Prepared:
5/31/2017 3:55 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.280991	1,083,996	304,593	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.340994	117,483	40,061	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.556576	20,265	11,279	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.059521	55,984	3,332	col. 2, line 15.00		4.00
4.01 Cost of Medical Supplies 1	71.01	0.597860	0	0	col. 2, line 15.01		4.01
5.00 Cost of Drugs	73.00	0.096957	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0012 HHA CCN: 14-7131	Period: From 01/01/2016 To 12/31/2016	Worksheet H-4 Part I-II Date/Time Prepared: 5/31/2017 3:55 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount 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(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	475,193
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	3,337
13.00	Total PPS Reimbursement - LUPA Episodes		0	14,798
14.00	Total PPS Reimbursement - PEP Episodes		0	776
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	457
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	494,561
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	494,561
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	494,561
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	494,561
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
31.00	Subtotal (see instructions)		0	494,561
31.01	Sequestration adjustment (see instructions)		0	9,891
32.00	Interim payments (see instructions)		0	484,670
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 14-0012
HHA CCN: 14-7131

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

Worksheet H-5
Date/Time Prepared:
5/31/2017 3:55 pm
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		0		484,670	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			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		484,670	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		484,670	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0012	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 5/31/2017 3:55 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		689,487	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		12,360	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)		23.38	3.00
4.00	Number of interns & residents (see instructions)		5.62	4.00
5.00	Indirect medical education percentage (see instructions)		7.02	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)		48,402	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		750,249	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