

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: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 4/10/2017 1:14 pm
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PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 4/10/2017 Time: 1:14 pm
 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 6. Date Received: 10. NPR Date:
 (1) As Submitted 7. Contractor No. 11. Contractor's Vendor Code: 4
 (2) Settled without Audit 8. Initial Report for this Provider CCN 12. If line 5, column 1 is 4: Enter
 (3) Settled with Audit 9. Final Report for this Provider CCN number of times reopened = 0-9.
 (4) Reopened
 (5) Amended

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 SSM HEALTH GOOD SAMARITAN HOSPITAL (14-0046) 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	37,799	110,157	-8,124	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	40,001	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	77,800	110,157	-8,124	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: 14-0046		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 4/10/2017 1:12 pm			
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 1 GOOD SAMARITAN WAY			PO Box:				1.00				
2.00	City: MT. VERNON			State: IL		Zip Code: 62864		County: JEFFERSON			2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		SSM HEALTH GOOD SAMARITAN HOSPITAL		140046	99914	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF		GOOD SAMARITAN REHABILITATION UNIT		14T046	99914	5	01/01/1990	N	P	P	5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2016	12/31/2016		20.00		
21.00	Type of Control (see instructions)						1		21.00			
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	Y		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3	N		23.00		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			5,749	1,270	0	9	113	317	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.			233	50	0	0	0		25.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 4/10/2017 1:12 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		N	40.00
		V	XVII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)		N		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	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	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N		N	48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.		N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.		N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.		N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.		N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)		N			60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site		Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
		1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 67.00	
				1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00	
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y		75.00	
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N		0	76.00
				1.00			
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00	
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00	
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N		87.00	
				V	XIX		
				1.00	2.00		
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00	

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		V		XIX			
		1.00		2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00	
Rural Providers							
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N				105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.					107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		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.	Y				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	4,044,920		2,015,016		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: 14-0046		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 4/10/2017 1:12 pm	
		1.00	2.00				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		269020		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: SSM HEALTH	Contractor's Name: A		Contractor's Number: 05301		141.00	
142.00	Street: 10101 WOODFIELD LANE	PO Box:				142.00	
143.00	City: ST. LOUIS	State: MO		Zip Code: 63132		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
						1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
						1.00	
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			0		168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.25		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 4/10/2017 1:12 pm
		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	08/02/2016	10/30/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 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: 14-0046		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part II Date/Time Prepared: 4/10/2017 1:12 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)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	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.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/03/2017	Y	04/03/2017		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 4/10/2017 1:12 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?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ERIC		LAMOND	41.00
42.00	Enter the employer/company name of the cost report preparer.	SSM HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-989-3162		ERIC.LAMOND@SSMHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 4/10/2017 1:12 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.	MANAGER - GOVERNMENT 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: 14-0046

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

Worksheet S-3
Part I
Date/Time Prepared:
4/10/2017 1:12 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	99	36,189	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)		99	36,189	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	16	5,856	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)		115	42,045	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	10	3,660		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		125			0	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: 14-0046

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

Worksheet S-3
Part I
Date/Time Prepared:
4/10/2017 1:12 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents			
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
	6.00	7.00	8.00	9.00	10.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	14,455	4,108	25,245			1.00
2.00	HMO and other (see instructions)	1,330	1,301				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	14	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)	14,455	4,108	25,245			7.00
8.00	INTENSIVE CARE UNIT	1,123	467	2,749			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		1,265	1,794			13.00
14.00	Total (see instructions)	15,578	5,840	29,788	0.00	904.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	1,641	283	2,195	0.00	16.00	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	920.00	27.00
28.00	Observation Bed Days		0	3,395			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			437			30.00
31.00	Employee discount days - IRF			32			31.00
32.00	Labor & delivery days (see instructions)	0	317	519			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: 14-0046

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

Worksheet S-3
Part I
Date/Time Prepared:
4/10/2017 1:12 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	3,591	1,664	7,667	1.00
2.00 HMO and other (see instructions)			329	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	3,591	1,664	7,667	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	159	18	214	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0046

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

Worksheet S-3
Part II
Date/Time Prepared:
4/10/2017 1:12 pm

	Worksheet A Line Number	Amount Reported	Reclassifi- cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	53,864,304	0	53,864,304	1,993,081.00	27.03
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		79,229	0	79,229	863.00	91.81
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,868,527	-215,417	1,653,110	99,662.00	16.59
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		768,801	0	768,801	21,372.00	35.97
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		649,117	0	649,117	4,984.00	130.24
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		9,411,690	0	9,411,690	202,958.00	46.37
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		22,673,901	0	22,673,901		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		867,606	0	867,606		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		28,356	0	28,356		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		214,043	0	214,043		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related		0	0	0		
25.51	Related organization wage-related		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	435,497	215,417	650,914	15,563.47	41.82
27.00	Administrative & General	5.00	3,687,448	11,107	3,698,555	119,181.46	31.03

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0046

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

Worksheet S-3
Part II
Date/Time Prepared:
4/10/2017 1:12 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	0.00	0.00	29.00
30.00	Operation of Plant	7.00	956,685	0	956,685	47,523.17	20.13	30.00
31.00	Laundry & Linen Service	8.00	141,779	0	141,779	9,662.02	14.67	31.00
32.00	Housekeeping	9.00	1,279,236	0	1,279,236	95,290.43	13.42	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,539,770	-1,125,422	414,348	28,582.41	14.50	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,125,422	1,125,422	77,634.00	14.50	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	874,479	0	874,479	24,986.40	35.00	38.00
39.00	Central Services and Supply	14.00	327,401	-11,107	316,294	21,075.26	15.01	39.00
40.00	Pharmacy	15.00	1,978,120	0	1,978,120	50,463.53	39.20	40.00
41.00	Medical Records & Medical Records Library	16.00	618,128	0	618,128	33,870.90	18.25	41.00
42.00	Social Service	17.00	1,268,878	0	1,268,878	42,659.10	29.74	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0046

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

Worksheet S-3
Part III
Date/Time Prepared:
4/10/2017 1:12 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)	53,864,304	0	53,864,304	1,993,081.00	27.03	1.00
2.00	Excluded area salaries (see instructions)	1,868,527	-215,417	1,653,110	99,662.00	16.59	2.00
3.00	Subtotal salaries (line 1 minus line 2)	51,995,777	215,417	52,211,194	1,893,419.00	27.58	3.00
4.00	Subtotal other wages & related costs (see inst.)	10,829,608	0	10,829,608	229,314.00	47.23	4.00
5.00	Subtotal wage-related costs (see inst.)	22,702,257	0	22,702,257	0.00	43.48	5.00
6.00	Total (sum of lines 3 thru 5)	85,527,642	215,417	85,743,059	2,122,733.00	40.39	6.00
7.00	Total overhead cost (see instructions)	13,107,421	215,417	13,322,838	566,492.15	23.52	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part IV Date/Time Prepared: 4/10/2017 1:12 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	407,866	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1,781,632	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	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	12,620,081	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	265,582	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	103,815	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	7,309	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	128,082	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	527,185	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	2,807,047	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	38,165	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	203,169	22.00
23.00	Tuition Reimbursement	53,254	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	18,943,187	24.00
Part B - Other than Core Related Cost			
25.00	OTHER- NON-CORE	46,868	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part V Date/Time Prepared: 4/10/2017 1:12 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		768,801	18,943,187
2.00	Hospital		768,801	18,943,187
3.00	Subprovider - IPF			
4.00	Subprovider - IRF		0	0
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	Hospital-Based SNF			
9.00	Hospital-Based NF			
10.00	Hospital-Based OLTC			
11.00	Hospital-Based HHA			
12.00	Separately Certified ASC			
13.00	Hospital-Based Hospice			
14.00	Hospital-Based Health Clinic RHC			
15.00	Hospital-Based Health Clinic FQHC			
16.00	Hospital-Based-CMHC			
17.00	Renal Dialysis		0	0
18.00	Other		0	0

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet S-10 Date/Time Prepared: 4/10/2017 1:12 pm
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			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)		0.282170	1.00		
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid		13,785,854	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00		
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00		
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		4,603,292	5.00		
6.00	Medicaid charges		110,477,347	6.00		
7.00	Medicaid cost (line 1 times line 6)		31,173,393	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)		12,784,247	8.00		
Children's Health Insurance Program (CHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone CHIP		0	9.00		
10.00	Stand-alone CHIP charges		0	10.00		
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00		
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00		
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00		
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00		
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00		
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00		
Uncompensated care (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00		
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00		
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		12,784,247	19.00		
			Uninsured patients	Insured patients		
			1.00	2.00		
20.00	Charity care charges for the entire facility (see instructions)		4,412,750	1,069,698	5,482,448	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)		1,245,146	301,837	1,546,983	21.00
22.00	Partial payment by patients approved for charity care		66,435	131,199	197,634	22.00
23.00	Cost of charity care (line 21 minus line 22)		1,178,711	170,638	1,349,349	23.00
			1.00			
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N			24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0			25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		7,479,910			26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		385,136			27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		7,094,774			28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		2,001,932			29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		3,351,281			30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		16,135,528			31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 14-0046		Period: From 01/01/2016 To 12/31/2016		Worksheet A	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		14,960,706	14,960,706	-66,164	14,894,542	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,931,759	5,931,759	0	5,931,759	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	435,497	22,210,706	22,646,203	244,778	22,890,981	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,687,448	27,943,210	31,630,658	188,594	31,819,252	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,704,517	1,704,517	38	1,704,555	6.00
7.00	00700	OPERATION OF PLANT	956,685	2,611,512	3,568,197	0	3,568,197	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	141,779	524,965	666,744	0	666,744	8.00
9.00	00900	HOUSEKEEPING	1,279,236	785,310	2,064,546	0	2,064,546	9.00
10.00	01000	DIETARY	1,539,770	1,099,764	2,639,534	-1,908,462	731,072	10.00
11.00	01100	CAFETERIA	0	0	0	1,929,242	1,929,242	11.00
13.00	01300	NURSING ADMINISTRATION	874,479	75,960	950,439	0	950,439	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	327,401	401,197	728,598	-11,107	717,491	14.00
15.00	01500	PHARMACY	1,978,120	6,130,514	8,108,634	-5,666,611	2,442,023	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	618,128	244,061	862,189	0	862,189	16.00
17.00	01700	SOCIAL SERVICE	1,268,878	173,066	1,441,944	0	1,441,944	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	16,689,121	3,863,468	20,552,589	-3,146,025	17,406,564	30.00
31.00	03100	INTENSIVE CARE UNIT	3,066,028	1,233,829	4,299,857	-476,206	3,823,651	31.00
41.00	04100	SUBPROVIDER - IIRF	881,393	65,364	946,757	-3,922	942,835	41.00
43.00	04300	NURSERY	0	0	0	1,021,279	1,021,279	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,471,592	12,237,881	15,709,473	-9,466,848	6,242,625	50.00
51.00	05100	RECOVERY ROOM	473,051	37,067	510,118	-34,327	475,791	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	832,639	832,639	52.00
53.00	05300	ANESTHESIOLOGY	0	860,522	860,522	-271,496	589,026	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,812,983	396,643	2,209,626	-287,113	1,922,513	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	99,669	101,494	201,163	0	201,163	55.00
56.00	05600	RADIOISOTOPE	241,919	563,757	805,676	-7,684	797,992	56.00
57.00	05700	CT SCAN	435,474	137,534	573,008	-65,877	507,131	57.00
58.00	05800	MRI	232,262	73,648	305,910	-59,320	246,590	58.00
59.00	05900	CARDIAC CATHETERIZATION	822,607	2,556,651	3,379,258	-2,471,238	908,020	59.00
60.00	06000	LABORATORY	1,975,561	3,924,028	5,899,589	-178,842	5,720,747	60.00
64.00	06400	INTRAVENOUS THERAPY	246,195	42,480	288,675	-41,058	247,617	64.00
65.00	06500	RESPIRATORY THERAPY	1,309,931	294,497	1,604,428	-176,554	1,427,874	65.00
66.00	06600	PHYSICAL THERAPY	1,198,454	45,083	1,243,537	-9,284	1,234,253	66.00
66.01	06601	CLINICAL NUTRITION	180,029	16,816	196,845	0	196,845	66.01
67.00	06700	OCCUPATIONAL THERAPY	761,280	202,718	963,998	-10,787	953,211	67.00
68.00	06800	SPEECH PATHOLOGY	286,235	7,285	293,520	-3,054	290,466	68.00
69.00	06900	ELECTROCARDIOLOGY	487,191	1,164,456	1,651,647	-23,884	1,627,763	69.00
69.01	06901	CARDIAC REHABILITATION	194,609	27,276	221,885	-1,383	220,502	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	60,673	20,243	80,916	-64	80,852	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	9,203,859	9,203,859	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	6,441,402	6,441,402	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,238,458	159,479	1,397,937	5,543,063	6,941,000	73.00
74.00	07400	RENAL DIALYSIS	24,226	546,497	570,723	-8,902	561,821	74.00
76.00	03950	ACUTE DIALYSIS	161,215	196,911	358,126	-163,848	194,278	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	483,497	369,722	853,219	-54,775	798,444	90.00
91.00	09100	EMERGENCY	2,936,096	934,389	3,870,485	-413,140	3,457,345	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	52,877,170	114,876,985	167,754,155	376,919	168,131,074	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	84,522	14,635	99,157	0	99,157	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	265,591	6,315	271,906	-177,525	94,381	192.00
194.00	07951	NONREIMBURSABLE DEPARTMENTS	637,021	2,253,978	2,890,999	-199,394	2,691,605	194.00
200.00		TOTAL (SUM OF LINES 118-199)	53,864,304	117,151,913	171,016,217	0	171,016,217	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0046

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

Worksheet A
Date/Time Prepared:
4/10/2017 1:12 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	-5,741,540	9,153,002	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,237,591	7,169,350	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-5,008,252	17,882,729	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,035,821	26,783,431	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,704,555	6.00
7.00	00700	OPERATION OF PLANT	-204,203	3,363,994	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	666,744	8.00
9.00	00900	HOUSEKEEPING	-2,296	2,062,250	9.00
10.00	01000	DIETARY	-250,097	480,975	10.00
11.00	01100	CAFETERIA	-583,561	1,345,681	11.00
13.00	01300	NURSING ADMINISTRATION	-3,304	947,135	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	717,491	14.00
15.00	01500	PHARMACY	-81,378	2,360,645	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,526	854,663	16.00
17.00	01700	SOCIAL SERVICE	-5,969	1,435,975	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-4,884,774	12,521,790	30.00
31.00	03100	INTENSIVE CARE UNIT	-1,044,142	2,779,509	31.00
41.00	04100	SUBPROVIDER - IRF	-50,449	892,386	41.00
43.00	04300	NURSERY	0	1,021,279	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-777,942	5,464,683	50.00
51.00	05100	RECOVERY ROOM	0	475,791	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	832,639	52.00
53.00	05300	ANESTHESIOLOGY	-433,025	156,001	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,203	1,920,310	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	-70,252	130,911	55.00
56.00	05600	RADIOISOTOPE	0	797,992	56.00
57.00	05700	CT SCAN	0	507,131	57.00
58.00	05800	MRI	0	246,590	58.00
59.00	05900	CARDIAC CATHETERIZATION	-20	908,000	59.00
60.00	06000	LABORATORY	-31,176	5,689,571	60.00
64.00	06400	INTRAVENOUS THERAPY	0	247,617	64.00
65.00	06500	RESPIRATORY THERAPY	-21,871	1,406,003	65.00
66.00	06600	PHYSICAL THERAPY	0	1,234,253	66.00
66.01	06601	CLINICAL NUTRITION	0	196,845	66.01
67.00	06700	OCCUPATIONAL THERAPY	-7,667	945,544	67.00
68.00	06800	SPEECH PATHOLOGY	0	290,466	68.00
69.00	06900	ELECTROCARDIOLOGY	-930,362	697,401	69.00
69.01	06901	CARDIAC REHABILITATION	-28,136	192,366	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-2,364	78,488	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	9,203,859	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	6,441,402	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-86,869	6,854,131	73.00
74.00	07400	RENAL DIALYSIS	-13,240	548,581	74.00
76.00	03950	ACUTE DIALYSIS	0	194,278	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-137,053	661,391	90.00
91.00	09100	EMERGENCY	-438,932	3,018,413	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-24,646,833	143,484,241	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	99,157	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	94,381	192.00
194.00	07951	NONREIMBURSABLE DEPARTMENTS	0	2,691,605	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-24,646,833	146,369,384	200.00

RECLASSIFICATIONS

Provider CCN: 14-0046

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

Worksheet A-6

Date/Time Prepared:
4/10/2017 1:12 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00	3.00	4.00	5.00		
A - OBSTETRICS UNIT COST					
1.00	NURSERY	43.00	892,516	128,763	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	727,660	104,979	2.00
	O		1,620,176	233,742	
E - SHARED DIETARY COST					
1.00	CAFETERIA	11.00	1,125,422	803,820	1.00
	O		1,125,422	803,820	
F - MAILROOM COST					
1.00	ADMINISTRATIVE & GENERAL	5.00	11,107	0	1.00
	O		11,107	0	
G - CHILD CARE DIETARY					
1.00	DIETARY	10.00	0	20,780	1.00
	O		0	20,780	
H - EMPLOYEE CHILD CARE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	215,417	29,361	1.00
	O		215,417	29,361	
L - MEDICAL PLAZA EXPENSES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	177,487	1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	38	2.00
	O		0	177,525	
M - CHILD CARE DEPRECIATION					
1.00	NONREIMBURSABLE DEPARTMENTS	194.00	0	66,164	1.00
	O		0	66,164	
N - C. SUPPLIES-CHARGEABLE IMPLANTABLES					
1.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	6,441,402	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
	O		0	6,441,402	
O - C SUPPLIES-CHARGEABLE MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	9,203,859	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
	O		0	9,203,859	
P - PHARM-DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,666,611	1.00
	O		0	5,666,611	
500.00	Grand Total: Increases		2,972,122	22,643,264	500.00

RECLASSIFICATIONS

Provider CCN: 14-0046

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

Worksheet A-6
Date/Time Prepared:
4/10/2017 1:12 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - OBSTETRICS UNIT COST							
1.00	ADULTS & PEDIATRICS	30.00	892,516	128,763	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	727,660	104,979	0		2.00
	0		1,620,176	233,742			
E - SHARED DIETARY COST							
1.00	DIETARY	10.00	1,125,422	803,820	0		1.00
	0		1,125,422	803,820			
F - MAILROOM COST							
1.00	CENTRAL SERVICE & SUPPLY	14.00	11,107	0	0		1.00
	0		11,107	0			
G - CHILD CARE DIETARY							
1.00	NONREIMBURSABLE DEPARTMENTS	194.00	0	20,780	0		1.00
	0		0	20,780			
H - EMPLOYEE CHILD CARE							
1.00	NONREIMBURSABLE DEPARTMENTS	194.00	215,417	29,361	0		1.00
	0		215,417	29,361			
L - MEDICAL PLAZA EXPENSES							
1.00	PHYSICIANS PRIVATE OFFICES	192.00	0	177,525	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	177,525			
M - CHILD CARE DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	66,164	9		1.00
	0		0	66,164			
N - C. SUPPLIES-CHARGEABLE IMPLANTABLES							
1.00	ADULTS & PEDIATRICS	30.00	0	8,693	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	176	0		2.00
3.00	OPERATING ROOM	50.00	0	5,162,082	0		3.00
4.00	RECOVERY ROOM	51.00	0	118	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	2,402	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	16,207	0		6.00
7.00	CARDIAC CATHETERIZATION	59.00	0	1,222,513	0		7.00
8.00	LABORATORY	60.00	0	2,323	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	536	0		9.00
10.00	ACUTE DIALYSIS	76.00	0	25,408	0		10.00
11.00	EMERGENCY	91.00	0	944	0		11.00
	0		0	6,441,402			
O - C SUPPLIES-CHARGEABLE MED SUPPLIES							
1.00	ADULTS & PEDIATRICS	30.00	0	1,283,414	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	476,030	0		2.00
3.00	SUBPROVIDER - IRF	41.00	0	3,922	0		3.00
4.00	OPERATING ROOM	50.00	0	4,304,766	0		4.00
5.00	RECOVERY ROOM	51.00	0	34,209	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	269,094	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	270,906	0		7.00
8.00	RADIOISOTOPE	56.00	0	7,684	0		8.00
9.00	CT SCAN	57.00	0	65,877	0		9.00
10.00	MRI	58.00	0	59,320	0		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	1,248,725	0		11.00
12.00	LABORATORY	60.00	0	176,519	0		12.00
13.00	INTRAVENOUS THERAPY	64.00	0	41,058	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	176,018	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	9,284	0		15.00
16.00	OCCUPATIONAL THERAPY	67.00	0	10,787	0		16.00
17.00	SPEECH PATHOLOGY	68.00	0	3,054	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	23,884	0		18.00
19.00	CARDIAC REHABILITATION	69.01	0	1,383	0		19.00
20.00	ELECTROENCEPHALOGRAPHY	70.00	0	64	0		20.00
21.00	DRUGS CHARGED TO PATIENTS	73.00	0	123,548	0		21.00
22.00	RENAL DIALYSIS	74.00	0	8,902	0		22.00
23.00	ACUTE DIALYSIS	76.00	0	138,440	0		23.00
24.00	CLINIC	90.00	0	54,775	0		24.00
25.00	EMERGENCY	91.00	0	412,196	0		25.00
	0		0	9,203,859			
P - PHARM-DRUGS CHARGED TO PATIENTS							
1.00	PHARMACY	15.00	0	5,666,611	0		1.00
	0		0	5,666,611			
500.00	Grand Total: Decreases		2,972,122	22,643,264			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0046

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

Worksheet A-7
Part I
Date/Time Prepared:
4/10/2017 1:12 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	632,759	0	0	0	0	1.00
2.00	Land Improvements	6,613,257	42,672	0	42,672	49,959	2.00
3.00	Buildings and Fixtures	155,553,988	2,190,890	0	2,190,890	5,526	3.00
4.00	Building Improvements	18,106,641	151,359	0	151,359	0	4.00
5.00	Fixed Equipment	14,487,858	348,693	0	348,693	13,385	5.00
6.00	Movable Equipment	57,261,134	1,672,734	0	1,672,734	360,100	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	252,655,637	4,406,348	0	4,406,348	428,970	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	252,655,637	4,406,348	0	4,406,348	428,970	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	632,759	0				1.00
2.00	Land Improvements	6,605,970	0				2.00
3.00	Buildings and Fixtures	157,739,352	0				3.00
4.00	Building Improvements	18,258,000	0				4.00
5.00	Fixed Equipment	14,823,166	0				5.00
6.00	Movable Equipment	58,573,768	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	256,633,015	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	256,633,015	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0046

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

Worksheet A-7
Part II
Date/Time Prepared:
4/10/2017 1:12 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	5,143,296	0	9,817,410	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,931,759	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	11,075,055	0	9,817,410	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	14,960,706				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,931,759				2.00
3.00	Total (sum of lines 1-2)	0	20,892,465				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet A-7 Part III Date/Time Prepared: 4/10/2017 1:12 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	188,155,393	0	188,155,393	0.854019	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	45,367,970	13,205,798	32,162,172	0.145981	0	2.00
3.00	Total (sum of lines 1-2)	233,523,363	13,205,798	220,317,565	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col.s. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	5,288,989	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	7,169,350	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	12,458,339	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of col.s. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	3,864,013	0	0	0	9,153,002	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	7,169,350	2.00
3.00	Total (sum of lines 1-2)	3,864,013	0	0	0	16,322,352	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0046

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

Worksheet A-8

Date/Time Prepared:
4/10/2017 1:12 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-340,731	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00		2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-9,215,833				10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	-366	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-12,539,380				12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-250,097	DIETARY	10.00	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	B	-81,247	PHARMACY	15.00	0	17.00
18.00 Sale of medical records and abstracts	B	-7,526	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	B	-583,561	CAFETERIA	11.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	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	B	-11,553	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	B	56,388	CAP REL COSTS-MVBLE EQUIP	2.00	9	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		0		0.00	0	33.00
33.02		0		0.00	0	33.02

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0046

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

Worksheet A-8

Date/Time Prepared:
4/10/2017 1:12 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
34.00	MISC REV	B	-121,192	ADMINISTRATIVE & GENERAL	5.00	0 34.00
35.00	MISC REV	B	-9,652	RADIOLOGY - THERAPEUTIC	55.00	0 35.00
36.00	MISC REV	B	-203,674	OPERATION OF PLANT	7.00	0 36.00
36.50	MISC REV	B	-625	LABORATORY	60.00	0 36.50
37.00	MISC REV	B	-13,568	RESPIRATORY THERAPY	65.00	0 37.00
38.00	VENDING COMMISSIONS AND RECYCLING	B	-2,296	HOUSEKEEPING	9.00	0 38.00
39.00	SOCIAL SERVICES REVENUE	B	-5,912	SOCIAL SERVICE	17.00	0 39.00
40.00	A&P REVENUE	B	-401	ADULTS & PEDIATRICS	30.00	0 40.00
40.05	ADVERTISING	A	-854	DRUGS CHARGED TO PATIENTS	73.00	0 40.05
41.00	ADVERTISING	A	-607	CARDIAC REHABILITATION	69.01	0 41.00
41.01	MISC REV	B	-18,204	CARDIAC REHABILITATION	69.01	0 41.01
41.20	ADVERTISING	A	-1,303	RADIOLOGY-DIAGNOSTIC	54.00	0 41.20
41.40	ADVERTISING	A	-1,388	SUBPROVIDER - IRF	41.00	0 41.40
44.00	ADVERTISING	A	-1,420	ADULTS & PEDIATRICS	30.00	0 44.00
45.01	NON-PATIENT TELEPHONE COST	A	-21,756	ADMINISTRATIVE & GENERAL	5.00	0 45.01
45.02	NON-PATIENT TELEPHONE DEPR	A	-9,204	CAP REL COSTS-MVBLE EQUIP	2.00	9 45.02
45.03	EMPLOYEE CHILD CARE	A	-224,314	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 45.03
45.04	REAL ESTATE TAXES	A	-360	ADMINISTRATIVE & GENERAL	5.00	0 45.04
45.05	ADVERTISING	A	-27,408	ADMINISTRATIVE & GENERAL	5.00	0 45.05
45.07	ADVERTISING	A	-551	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 45.07
45.08	LOBBYING DUES	A	-6,038	ADMINISTRATIVE & GENERAL	5.00	0 45.08
45.09	MGMT - CLAY	A	-379,473	ADMINISTRATIVE & GENERAL	5.00	0 45.09
45.10	GIFTS & ENTERTAINMENT	A	-20	CARDIAC CATHETERIZATION	59.00	0 45.10
45.11	GIFTS & ENTERTAINMENT	A	-72,252	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 45.11
45.12	GIFTS & ENTERTAINMENT	A	-97,781	ADMINISTRATIVE & GENERAL	5.00	0 45.12
45.13	NON-PATIENT TELEPHONE (SALARY)	A	-21,756	ADMINISTRATIVE & GENERAL	5.00	0 45.13
45.14	NON-PATIENT TELEPHONE (BENEFITS)	A	-9,204	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 45.14
45.15	GIFTS & ENTERTAINMENT	A	-249	OPERATION OF PLANT	7.00	0 45.15
45.16	ADVERTISING	A	-109	NURSING ADMINISTRATIVE	13.00	0 45.16
45.17	GIFTS & ENTERTAINMENT	A	-46	SUBPROVIDER - IRF	41.00	0 45.17
45.18	GIFTS & ENTERTAINMENT	A	-3,195	NURSING ADMINISTRATIVE	13.00	0 45.18
45.19	GIFTS & ENTERTAINMENT	A	-57	SOCIAL SERVICE	17.00	0 45.19
45.20	PERSONAL USE (DUES)	A	-750	ADMINISTRATIVE & GENERAL	5.00	0 45.20
45.21	GIFTS & ENTERTAINMENT	A	-1,544	ADULTS & PEDIATRICS	30.00	0 45.21
45.22	GIFTS & ENTERTAINMENT	A	-765	INTENSIVE CARE UNIT	31.00	0 45.22
45.23	GIFTS & ENTERTAINMENT	A	-478	OPERATING ROOM	50.00	0 45.23
45.24	GIFTS & ENTERTAINMENT	A	-546	LABORATORY	60.00	0 45.24
45.25	GIFTS & ENTERTAINMENT	A	-369	RESPIRATORY THERAPY	65.00	0 45.25
45.26	ADVERTISING	A	-669	OPERATING ROOM	50.00	0 45.26
45.27	GIFTS & ENTERTAINMENT	A	-55	ELECTROCARDIOLOGY	69.00	0 45.27
45.28	ADVERTISING	A	-1,036	CLINIC	90.00	0 45.28
45.29	ADVERTISING (SUB)	A	-131	PHARMACY	15.00	0 45.29
45.30	MD RECRUITMENT	A	-341,510	ADMINISTRATIVE & GENERAL	5.00	0 45.30
45.31	ADVERTISING	A	-280	OPERATION OF PLANT	7.00	0 45.31
45.32	GIFTS & ENTERTAINMENT	A	-60	DRUGS CHARGED TO PATIENTS	73.00	0 45.32
45.33	GIFTS & ENTERTAINMENT	A	-814	EMERGENCY	91.00	0 45.33
45.34	MD RECRUITMENT	A	-64,184	ADULTS & PEDIATRICS	30.00	0 45.34
45.35	GIFTS & ENTERTAINMENT	A	-534	RADIOLOGY-DIAGNOSTIC	54.00	0 45.35
45.36	MD RECRUITMENT	A	-4,333	OPERATING ROOM	50.00	0 45.36
45.75			0		0.00	0 45.75
46.00			0		0.00	0 46.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-24,646,833			50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS
 Provider CCN: 14-0046
 Period: From 01/01/2016 To 12/31/2016
 Worksheet A-8-1
 Date/Time Prepared: 4/10/2017 1:12 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	223,410	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	1,190,407	0
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE - INTEREST	0	5,612,666
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	12,962,753	17,664,684
4.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	12,693,785	16,246,430
4.03	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	-85,830	125
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			26,984,525	39,523,905

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

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

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

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

6.00	B	0.00	SSM	0.00	6.00
7.00		0.00		0.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 14-0046

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

Worksheet A-8-1

Date/Time Prepared:
4/10/2017 1:12 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	223,410	9		1.00
2.00	1,190,407	9		2.00
3.00	-5,612,666	11		3.00
4.00	-4,701,931	0		4.00
4.01	-3,552,645	0		4.01
4.03	-85,955	0		4.03
5.00	-12,539,380			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:			

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0046

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

Worksheet A-8-2

Date/Time Prepared:
4/10/2017 1:12 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	5.00	ADMINISTRATIVE & GENERAL	621,034	307,722	313,311	159,800	2,029	1.00
2.00	30.00	ADULTS & PEDIATRICS	4,832,225	4,817,225	15,000	159,800	225	2.00
3.00	31.00	INTENSIVE CARE UNIT	1,056,053	1,038,112	17,940	159,800	165	3.00
4.00	41.00	SUBPROVIDER - IRF	52,242	45,832	6,410	159,800	42	4.00
5.00	50.00	OPERATING ROOM	772,462	772,462	0	159,800	0	5.00
6.00	53.00	ANESTHESIOLOGY	474,175	390,835	83,340	167,500	511	6.00
7.00	55.00	RADIOLOGY - THERAPEUTIC	60,600	60,600	0	217,600	0	7.00
8.00	60.00	LABORATORY	98,905	0	98,905	208,000	689	8.00
9.00	67.00	OCCUPATIONAL THERAPY	33,173	0	33,173	159,800	332	9.00
10.00	69.00	ELECTROCARDIOLOGY	1,098,558	879,554	219,003	159,800	2,190	10.00
11.00	69.01	CARDIAC REHABILITATION	18,544	0	18,544	159,800	120	11.00
12.00	70.00	ELECTROENCEPHALOGRAPHY	10,200	0	10,200	159,800	102	12.00
13.00	74.00	RENAL DIALYSIS	24,226	0	24,226	159,800	143	13.00
14.00	91.00	EMERGENCY	438,118	438,118	0	159,800	0	14.00
15.00	65.00	RESPIRATORY THERAPY	10,700	4,144	6,556	159,800	36	15.00
16.00	90.00	CLINIC	136,017	136,017	0	159,800	0	16.00
200.00			9,737,232	8,890,621	846,608		6,584	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	5.00	ADMINISTRATIVE & GENERAL	155,882	7,794	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	17,286	864	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	12,676	634	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	3,227	161	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	41,150	2,058	0	0	0	6.00
7.00	55.00	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	68,900	3,445	0	0	0	8.00
9.00	67.00	OCCUPATIONAL THERAPY	25,506	1,275	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	168,251	8,413	0	0	0	10.00
11.00	69.01	CARDIAC REHABILITATION	9,219	461	0	0	0	11.00
12.00	70.00	ELECTROENCEPHALOGRAPHY	7,836	392	0	0	0	12.00
13.00	74.00	RENAL DIALYSIS	10,986	549	0	0	0	13.00
14.00	91.00	EMERGENCY	0	0	0	0	0	14.00
15.00	65.00	RESPIRATORY THERAPY	2,766	138	0	0	0	15.00
16.00	90.00	CLINIC	0	0	0	0	0	16.00
200.00			523,685	26,184	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	155,882	157,429	465,152	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	17,286	0	4,817,225	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	12,676	5,264	1,043,377	3.00
4.00	41.00	SUBPROVIDER - IRF	0	3,227	3,183	49,015	4.00
5.00	50.00	OPERATING ROOM	0	0	0	772,462	5.00
6.00	53.00	ANESTHESIOLOGY	0	41,150	42,190	433,025	6.00
7.00	55.00	RADIOLOGY - THERAPEUTIC	0	0	0	60,600	7.00
8.00	60.00	LABORATORY	0	68,900	30,005	30,005	8.00
9.00	67.00	OCCUPATIONAL THERAPY	0	25,506	7,667	7,667	9.00
10.00	69.00	ELECTROCARDIOLOGY	0	168,251	50,752	930,307	10.00
11.00	69.01	CARDIAC REHABILITATION	0	9,219	9,325	9,325	11.00
12.00	70.00	ELECTROENCEPHALOGRAPHY	0	7,836	2,364	2,364	12.00
13.00	74.00	RENAL DIALYSIS	0	10,986	13,240	13,240	13.00
14.00	91.00	EMERGENCY	0	0	0	438,118	14.00
15.00	65.00	RESPIRATORY THERAPY	0	2,766	3,790	7,934	15.00
16.00	90.00	CLINIC	0	0	0	136,017	16.00
200.00			0	523,685	325,209	9,215,833	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

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

Worksheet B
Part I
Date/Time Prepared:
4/10/2017 1:12 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	9,153,002	9,153,002			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	7,169,350		7,169,350		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	17,882,729	262,799	0	18,145,528	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	26,783,431	0	595,078	1,261,192	5.00
6.00 00600	MAINTENANCE & REPAIRS	1,704,555	1,250,084	782	0	6.00
7.00 00700	OPERATION OF PLANT	3,363,994	407,275	4,294,616	326,226	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	666,744	114,760	525	48,346	8.00
9.00 00900	HOUSEKEEPING	2,062,250	267,603	9,517	436,214	9.00
10.00 01000	DIETARY	480,975	103,317	6,218	141,291	10.00
11.00 01100	CAFETERIA	1,345,681	269,870	0	383,764	11.00
13.00 01300	NURSING ADMINISTRATION	947,135	51,200	201,016	298,194	13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	717,491	0	27,251	107,855	14.00
15.00 01500	PHARMACY	2,360,645	91,171	11,694	674,531	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	854,663	109,416	1,048	210,779	16.00
17.00 01700	SOCIAL SERVICE	1,435,975	91,225	0	432,682	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	12,521,790	1,512,831	57,727	5,690,890	30.00
31.00 03100	INTENSIVE CARE UNIT	2,779,509	472,671	60,524	1,045,503	31.00
41.00 04100	SUBPROVIDER - IRF	892,386	243,663	0	300,551	41.00
43.00 04300	NURSERY	1,021,279	28,906	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,464,683	848,125	388,223	1,155,775	50.00
51.00 05100	RECOVERY ROOM	475,791	0	7,003	161,308	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	832,639	260,721	0	0	52.00
53.00 05300	ANESTHESIOLOGY	156,001	6,909	16,376	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,920,310	604,327	292,496	616,235	54.00
55.00 05500	RADIOLOGY - THERAPEUTIC	130,911	0	0	33,987	55.00
56.00 05600	RADIOISOTOPE	797,992	0	49,196	82,493	56.00
57.00 05700	CT SCAN	507,131	104,099	132,020	148,450	57.00
58.00 05800	MRI	246,590	58,595	6,486	79,199	58.00
59.00 05900	CARDIAC CATHETERIZATION	908,000	177,727	63,704	240,212	59.00
60.00 06000	LABORATORY	5,689,571	239,804	90,832	673,658	60.00
64.00 06400	INTRAVENOUS THERAPY	247,617	36,544	841	83,952	64.00
65.00 06500	RESPIRATORY THERAPY	1,406,003	39,729	48,440	441,013	65.00
66.00 06600	PHYSICAL THERAPY	1,234,253	100,942	3,331	408,668	66.00
66.01 06601	CLINICAL NUTRITION	196,845	0	0	61,389	66.01
67.00 06700	OCCUPATIONAL THERAPY	945,544	92,926	326	259,593	67.00
68.00 06800	SPEECH PATHOLOGY	290,466	18,380	0	97,605	68.00
69.00 06900	ELECTROCARDIOLOGY	697,401	472,860	54,535	166,130	69.00
69.01 06901	CARDIAC REHABILITATION	192,366	0	8,545	66,361	69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	78,488	0	3,548	20,689	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	9,203,859	0	0	76,044	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	6,441,402	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	6,854,131	0	5,722	422,294	73.00
74.00 07400	RENAL DIALYSIS	548,581	0	3,037	8,261	74.00
76.00 03950	ACUTE DIALYSIS	194,278	28,609	20,167	54,974	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	661,391	58,352	54,884	164,871	90.00
91.00 09100	EMERGENCY	3,018,413	420,608	41,003	1,001,197	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	143,484,241	8,846,048	6,556,711	17,882,376	142,301,496
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	99,157	38,406	567	28,822	166,952
192.00 19200	PHYSICIANS PRIVATE OFFICES	94,381	0	214,567	90,565	399,513
194.00 07951	NONREIMBURSABLE DEPARTMENTS	2,691,605	268,548	397,505	143,765	3,501,423
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	146,369,384	9,153,002	7,169,350	18,145,528	146,369,384

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

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

Worksheet B
Part I
Date/Time Prepared:
4/10/2017 1:12 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	28,639,701					5.00
6.00	00600	718,956	3,674,377				6.00
7.00	00700	2,041,524	1,851,893	12,285,528			7.00
8.00	00800	202,003	0	194,929	1,227,307		8.00
9.00	00900	675,208	153,714	454,544	6,137	4,065,187	9.00
10.00	01000	178,023	202	175,491	2,312	61,310	10.00
11.00	01100	486,367	1,109,337	458,395	6,279	160,146	11.00
13.00	01300	364,303	136	86,966	0	30,383	13.00
14.00	01400	207,409	2,458	0	0	0	14.00
15.00	01500	763,382	1,606	154,861	0	54,103	15.00
16.00	01600	286,059	0	185,852	0	64,930	16.00
17.00	01700	476,775	51,924	154,953	0	54,135	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	4,812,565	3,021	2,569,653	576,344	897,740	30.00
31.00	03100	1,060,208	271	802,868	118,680	280,492	31.00
41.00	04100	349,477	0	413,880	61,365	144,594	41.00
43.00	04300	255,475	0	49,099	18,410	17,153	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,911,302	15,634	1,440,605	102,234	503,293	50.00
51.00	05100	156,689	0	0	0	0	51.00
52.00	05200	265,978	0	442,854	0	154,717	52.00
53.00	05300	43,614	0	11,736	0	4,100	53.00
54.00	05400	835,225	100,282	1,026,495	111,807	358,619	54.00
55.00	05500	40,114	1,809	0	0	0	55.00
56.00	05600	226,161	0	0	0	0	56.00
57.00	05700	216,921	4,230	176,821	0	61,759	57.00
58.00	05800	95,086	75,554	99,528	24,547	34,771	58.00
59.00	05900	338,054	0	301,883	12,273	105,467	59.00
60.00	06000	1,628,396	12,708	407,325	0	142,304	60.00
64.00	06400	89,754	34,102	62,073	0	21,686	64.00
65.00	06500	470,767	1,675	67,482	0	23,576	65.00
66.00	06600	425,035	16,455	171,457	0	59,901	66.00
66.01	06601	62,820	23,463	0	0	0	66.01
67.00	06700	315,855	0	157,841	0	55,144	67.00
68.00	06800	98,876	217	31,220	0	10,907	68.00
69.00	06900	338,366	12,512	803,188	6,137	280,604	69.00
69.01	06901	65,018	861	0	0	0	69.01
70.00	07000	24,990	0	0	3,068	0	70.00
71.00	07100	2,257,494	84	0	0	0	71.00
72.00	07200	1,566,981	0	0	0	0	72.00
73.00	07300	1,771,506	14,087	0	39,642	0	73.00
74.00	07400	136,200	2,207	0	2,700	0	74.00
76.00	03950	72,500	917	48,595	0	16,977	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	228,549	688	99,115	0	34,627	90.00
91.00	09100	1,090,133	10,592	714,434	126,781	249,597	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		27,650,118	3,502,639	11,764,143	1,218,716	3,883,035	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	40,614	146	65,236	0	22,791	190.00
192.00	19200	97,188	68,913	0	0	0	192.00
194.00	07951	851,781	102,679	456,149	8,591	159,361	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		28,639,701	3,674,377	12,285,528	1,227,307	4,065,187	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

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

Worksheet B
Part I
Date/Time Prepared:
4/10/2017 1:12 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	1,149,139					10.00
11.00	01100	0	4,219,839				11.00
13.00	01300	0	65,935	2,045,268			13.00
14.00	01400	0	54,946	27,374	1,144,784		14.00
15.00	01500	0	131,870	65,546	950	4,310,359	15.00
16.00	01600	0	87,913	43,994	0	0	16.00
17.00	01700	0	115,386	55,408	5	2	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	843,177	1,467,052	721,449	94,459	30	30.00
31.00	03100	42,219	241,762	120,123	34,813	50	31.00
41.00	04100	47,382	82,419	41,161	287	0	41.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	62,254	313,191	152,702	692,069	4,998	50.00
51.00	05100	0	32,967	16,715	2,509	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	19,848	1,130	53.00
54.00	05400	0	175,827	86,872	20,989	0	54.00
55.00	05500	0	10,989	5,470	0	0	55.00
56.00	05600	0	16,484	8,530	562	0	56.00
57.00	05700	0	43,957	21,300	4,816	0	57.00
58.00	05800	0	21,978	10,057	4,337	0	58.00
59.00	05900	0	49,451	24,173	180,660	0	59.00
60.00	06000	0	247,256	120,918	13,074	0	60.00
64.00	06400	0	21,978	10,481	0	0	64.00
65.00	06500	0	142,859	69,171	3,002	0	65.00
66.00	06600	0	109,892	54,512	12,907	1,970	66.00
66.01	06601	0	21,978	9,958	679	0	66.01
67.00	06700	0	71,430	34,720	0	0	67.00
68.00	06800	0	21,978	11,231	789	276	68.00
69.00	06900	0	54,946	27,953	223	0	69.00
69.01	06901	0	21,978	9,549	1,746	0	69.01
70.00	07000	0	5,495	3,146	101	0	70.00
71.00	07100	0	43,957	20,342	5	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	137,365	68,003	9,032	3,351,867	73.00
74.00	07400	0	0	91	651	0	74.00
76.00	03950	0	10,989	6,406	11,978	8	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	49,451	25,547	4,004	8,789	90.00
91.00	09100	17,272	269,235	132,947	30,203	50	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		1,012,304	4,142,914	2,005,849	1,144,698	3,369,170	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	16,484	9,071	37	0	190.00
192.00	19200	0	16,484	8,554	49	0	192.00
194.00	07951	136,835	43,957	21,794	0	941,189	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,149,139	4,219,839	2,045,268	1,144,784	4,310,359	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0046

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

Worksheet B
Part I
Date/Time Prepared:
4/10/2017 1:12 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,844,654				16.00
17.00	01700	SOCIAL SERVICE	0	2,868,470			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	153,680	2,352,145	34,274,553	0	34,274,553
31.00	03100	INTENSIVE CARE UNIT	21,122	286,847	7,367,662	0	7,367,662
41.00	04100	SUBPROVIDER - IRF	7,893	229,478	2,814,536	0	2,814,536
43.00	04300	NURSERY	5,866	0	1,396,188	0	1,396,188
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	252,353	0	13,307,441	0	13,307,441
51.00	05100	RECOVERY ROOM	39,346	0	892,328	0	892,328
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,445	0	1,982,354	0	1,982,354
53.00	05300	ANESTHESIOLOGY	45,200	0	304,914	0	304,914
54.00	05400	RADIOLOGY-DIAGNOSTIC	94,929	0	6,244,413	0	6,244,413
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	223,280	0	223,280
56.00	05600	RADIOISOTOPE	33,026	0	1,214,444	0	1,214,444
57.00	05700	CT SCAN	165,434	0	1,586,938	0	1,586,938
58.00	05800	MRI	40,202	0	796,930	0	796,930
59.00	05900	CARDIAC CATHETERIZATION	94,493	0	2,496,097	0	2,496,097
60.00	06000	LABORATORY	276,163	0	9,542,009	0	9,542,009
64.00	06400	INTRAVENOUS THERAPY	6,421	0	615,449	0	615,449
65.00	06500	RESPIRATORY THERAPY	68,969	0	2,782,686	0	2,782,686
66.00	06600	PHYSICAL THERAPY	26,140	0	2,625,463	0	2,625,463
66.01	06601	CLINICAL NUTRITION	123	0	377,255	0	377,255
67.00	06700	OCCUPATIONAL THERAPY	10,584	0	1,943,963	0	1,943,963
68.00	06800	SPEECH PATHOLOGY	3,783	0	585,728	0	585,728
69.00	06900	ELECTROCARDIOLOGY	59,022	0	2,973,877	0	2,973,877
69.01	06901	CARDIAC REHABILITATION	3,032	0	369,456	0	369,456
70.00	07000	ELECTROENCEPHALOGRAPHY	868	0	140,393	0	140,393
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	34,901	0	11,636,686	0	11,636,686
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	74,741	0	8,083,124	0	8,083,124
73.00	07300	DRUGS CHARGED TO PATIENTS	173,172	0	12,846,821	0	12,846,821
74.00	07400	RENAL DIALYSIS	6,936	0	708,664	0	708,664
76.00	03950	ACUTE DIALYSIS	20,088	0	486,486	0	486,486
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	6,858	0	1,397,126	0	1,397,126
91.00	09100	EMERGENCY	92,874	0	7,215,339	0	7,215,339
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)				0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,843,664	2,868,470	139,232,603	0	139,232,603
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	321,331	0	321,331
192.00	19200	PHYSICIANS PRIVATE OFFICES	990	0	591,691	0	591,691
194.00	07951	NONREIMBURSABLE DEPARTMENTS	0	0	6,223,759	0	6,223,759
200.00		Cross Foot Adjustments			0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,844,654	2,868,470	146,369,384	0	146,369,384

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 4/10/2017 1:12 pm
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Line	Code	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
				1.00	2.00			
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	262,799	0	262,799	262,799	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	617,074	0	595,078	1,212,152	18,267	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,250,084	782	1,250,866	0	6.00
7.00	00700	OPERATION OF PLANT	54,128	407,275	4,294,616	4,756,019	4,725	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	114,760	525	115,285	700	8.00
9.00	00900	HOUSEKEEPING	44,808	267,603	9,517	321,928	6,318	9.00
10.00	01000	DIETARY	0	103,317	6,218	109,535	2,046	10.00
11.00	01100	CAFETERIA	0	269,870	0	269,870	5,558	11.00
13.00	01300	NURSING ADMINISTRATION	0	51,200	201,016	252,216	4,319	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	78,311	0	27,251	105,562	1,562	14.00
15.00	01500	PHARMACY	218,801	91,171	11,694	321,666	9,770	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	109,416	1,048	110,464	3,053	16.00
17.00	01700	SOCIAL SERVICE	0	91,225	0	91,225	6,267	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	49,657	1,512,831	57,727	1,620,215	82,409	30.00
31.00	03100	INTENSIVE CARE UNIT	5,399	472,671	60,524	538,594	15,143	31.00
41.00	04100	SUBPROVIDER - IRF	0	243,663	0	243,663	4,353	41.00
43.00	04300	NURSERY	0	28,906	0	28,906	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	381,126	848,125	388,223	1,617,474	16,740	50.00
51.00	05100	RECOVERY ROOM	0	0	7,003	7,003	2,336	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	260,721	0	260,721	0	52.00
53.00	05300	ANESTHESIOLOGY	2,670	6,909	16,376	25,955	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,790	604,327	292,496	918,613	8,926	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	22,493	0	0	22,493	492	55.00
56.00	05600	RADIOISOTOPE	0	0	49,196	49,196	1,195	56.00
57.00	05700	CT SCAN	0	104,099	132,020	236,119	2,150	57.00
58.00	05800	MRI	0	58,595	6,486	65,081	1,147	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	177,727	63,704	241,431	3,479	59.00
60.00	06000	LABORATORY	328	239,804	90,832	330,964	9,757	60.00
64.00	06400	INTRAVENOUS THERAPY	0	36,544	841	37,385	1,216	64.00
65.00	06500	RESPIRATORY THERAPY	38,373	39,729	48,440	126,542	6,388	65.00
66.00	06600	PHYSICAL THERAPY	2,148	100,942	3,331	106,421	5,919	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0	889	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	92,926	326	93,252	3,760	67.00
68.00	06800	SPEECH PATHOLOGY	42	18,380	0	18,422	1,414	68.00
69.00	06900	ELECTROCARDIOLOGY	913	472,860	54,535	528,308	2,406	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	8,545	8,545	961	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	6,762	0	3,548	10,310	300	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	1,101	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	5,722	5,722	6,117	73.00
74.00	07400	RENAL DIALYSIS	0	0	3,037	3,037	120	74.00
76.00	03950	ACUTE DIALYSIS	0	28,609	20,167	48,776	796	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	72	58,352	54,884	113,308	2,388	90.00
91.00	09100	EMERGENCY	971	420,608	41,003	462,582	14,501	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)				0		92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,545,866	8,846,048	6,556,711	16,948,625	258,988	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	38,406	567	38,973	417	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	23,206	0	214,567	237,773	1,312	192.00
194.00	07951	NONREIMBURSABLE DEPARTMENTS	753,442	268,548	397,505	1,419,495	2,082	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,322,514	9,153,002	7,169,350	18,644,866	262,799	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0046		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 4/10/2017 1:12 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,230,419				5.00
6.00	00600	MAINTENANCE & REPAIRS	30,887	1,281,753			6.00
7.00	00700	OPERATION OF PLANT	87,706	646,009	5,494,459		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,678	0	87,178	211,841	8.00
9.00	00900	HOUSEKEEPING	29,008	53,620	203,286	1,059	615,219
10.00	01000	DIETARY	7,648	70	78,485	399	9,279
11.00	01100	CAFETERIA	20,895	386,974	205,008	1,084	24,236
13.00	01300	NURSING ADMINISTRATION	15,651	47	38,894	0	4,598
14.00	01400	CENTRAL SERVICE & SUPPLY	8,910	858	0	0	0
15.00	01500	PHARMACY	32,796	560	69,259	0	8,188
16.00	01600	MEDICAL RECORDS & LIBRARY	12,289	0	83,119	0	9,826
17.00	01700	SOCIAL SERVICE	20,483	18,113	69,300	0	8,193
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	206,780	1,054	1,149,223	99,481	135,863
31.00	03100	INTENSIVE CARE UNIT	45,548	94	359,067	20,485	42,449
41.00	04100	SUBPROVIDER - IRF	15,014	0	185,100	10,592	21,883
43.00	04300	NURSERY	10,975	0	21,959	3,178	2,596
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	82,111	5,454	644,282	17,646	76,168
51.00	05100	RECOVERY ROOM	6,732	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,427	0	198,058	0	23,415
53.00	05300	ANESTHESIOLOGY	1,874	0	5,249	0	621
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,882	34,982	459,080	19,299	54,273
55.00	05500	RADIOLOGY - THERAPEUTIC	1,723	631	0	0	0
56.00	05600	RADIOISOTOPE	9,716	0	0	0	0
57.00	05700	CT SCAN	9,319	1,476	79,080	0	9,346
58.00	05800	MRI	4,085	26,356	44,512	4,237	5,262
59.00	05900	CARDIAC CATHETERIZATION	14,523	0	135,011	2,118	15,961
60.00	06000	LABORATORY	69,958	4,433	182,168	0	21,536
64.00	06400	INTRAVENOUS THERAPY	3,856	11,896	27,761	0	3,282
65.00	06500	RESPIRATORY THERAPY	20,225	584	30,180	0	3,568
66.00	06600	PHYSICAL THERAPY	18,260	5,740	76,681	0	9,065
66.01	06601	CLINICAL NUTRITION	2,699	8,185	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	13,569	0	70,591	0	8,345
68.00	06800	SPEECH PATHOLOGY	4,248	76	13,962	0	1,651
69.00	06900	ELECTROCARDIOLOGY	14,537	4,365	359,210	1,059	42,466
69.01	06901	CARDIAC REHABILITATION	2,793	300	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	1,074	0	0	530	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	96,984	29	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	67,319	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	76,106	4,914	0	6,842	0
74.00	07400	RENAL DIALYSIS	5,851	770	0	466	0
76.00	03950	ACUTE DIALYSIS	3,115	320	21,733	0	2,569
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	9,819	240	44,327	0	5,240
91.00	09100	EMERGENCY	46,833	3,695	319,517	21,883	37,774
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,187,906	1,221,845	5,261,280	210,358	587,653
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	1,745	51	29,176	0	3,449
192.00	19200	PHYSICIANS PRIVATE OFFICES	4,175	24,039	0	0	0
194.00	07951	NONREIMBURSABLE DEPARTMENTS	36,593	35,818	204,003	1,483	24,117
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,230,419	1,281,753	5,494,459	211,841	615,219

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0046		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 4/10/2017 1:12 pm	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	207,462					10.00
11.00	01100	CAFETERIA	0	913,625				11.00
13.00	01300	NURSING ADMINISTRATION	0	14,275	330,000			13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	11,896	4,417	133,205		14.00
15.00	01500	PHARMACY	0	28,551	10,576	111	481,477	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,034	7,098	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	24,982	8,940	1	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	152,225	317,629	116,403	10,991	3	30.00
31.00	03100	INTENSIVE CARE UNIT	7,622	52,343	19,382	4,051	6	31.00
41.00	04100	SUBPROVIDER - IRF	8,554	17,844	6,641	33	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,239	67,808	24,638	80,529	558	50.00
51.00	05100	RECOVERY ROOM	0	7,138	2,697	292	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,309	126	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	38,068	14,017	2,442	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	2,379	882	0	0	55.00
56.00	05600	RADIOISOTOPE	0	3,569	1,376	65	0	56.00
57.00	05700	CT SCAN	0	9,517	3,437	560	0	57.00
58.00	05800	MRI	0	4,758	1,623	505	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	10,707	3,900	21,020	0	59.00
60.00	06000	LABORATORY	0	53,533	19,510	1,521	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	4,758	1,691	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	30,930	11,161	349	0	65.00
66.00	06600	PHYSICAL THERAPY	0	23,792	8,795	1,502	220	66.00
66.01	06601	CLINICAL NUTRITION	0	4,758	1,607	79	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	15,465	5,602	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,758	1,812	92	31	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,896	4,510	26	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	4,758	1,541	203	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,190	508	12	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	9,517	3,282	1	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	29,740	10,972	1,051	374,411	73.00
74.00	07400	RENAL DIALYSIS	0	0	15	76	0	74.00
76.00	03950	ACUTE DIALYSIS	0	2,379	1,034	1,394	1	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	10,707	4,122	466	982	90.00
91.00	09100	EMERGENCY	3,118	58,291	21,451	3,514	6	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	182,758	896,970	323,640	133,195	376,344	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	3,569	1,464	4	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	3,569	1,380	6	0	192.00
194.00	07951	NONREIMBURSABLE DEPARTMENTS	24,704	9,517	3,516	0	105,133	194.00
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)	207,462	913,625	330,000	133,205	481,477	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0046		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 4/10/2017 1:12 pm	
Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	244,883					16.00
17.00	01700	SOCIAL SERVICE	0	247,504				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,409	202,954	4,115,639	0	4,115,639	30.00
31.00	03100	INTENSIVE CARE UNIT	2,805	24,750	1,132,339	0	1,132,339	31.00
41.00	04100	SUBPROVIDER - IRF	1,048	19,800	534,525	0	534,525	41.00
43.00	04300	NURSERY	779	0	68,393	0	68,393	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	33,513	0	2,678,160	0	2,678,160	50.00
51.00	05100	RECOVERY ROOM	5,225	0	31,423	0	31,423	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,379	0	497,000	0	497,000	52.00
53.00	05300	ANESTHESIOLOGY	6,003	0	42,137	0	42,137	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,607	0	1,598,189	0	1,598,189	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	28,600	0	28,600	55.00
56.00	05600	RADIOISOTOPE	4,386	0	69,503	0	69,503	56.00
57.00	05700	CT SCAN	21,970	0	372,974	0	372,974	57.00
58.00	05800	MRI	5,339	0	162,905	0	162,905	58.00
59.00	05900	CARDIAC CATHETERIZATION	12,549	0	460,699	0	460,699	59.00
60.00	06000	LABORATORY	36,584	0	729,964	0	729,964	60.00
64.00	06400	INTRAVENOUS THERAPY	853	0	92,698	0	92,698	64.00
65.00	06500	RESPIRATORY THERAPY	9,159	0	239,086	0	239,086	65.00
66.00	06600	PHYSICAL THERAPY	3,471	0	259,866	0	259,866	66.00
66.01	06601	CLINICAL NUTRITION	16	0	18,233	0	18,233	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,406	0	211,990	0	211,990	67.00
68.00	06800	SPEECH PATHOLOGY	502	0	46,968	0	46,968	68.00
69.00	06900	ELECTROCARDIOLOGY	7,838	0	976,621	0	976,621	69.00
69.01	06901	CARDIAC REHABILITATION	403	0	19,504	0	19,504	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	115	0	14,039	0	14,039	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	4,635	0	115,549	0	115,549	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	9,926	0	77,245	0	77,245	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,998	0	538,873	0	538,873	73.00
74.00	07400	RENAL DIALYSIS	921	0	11,256	0	11,256	74.00
76.00	03950	ACUTE DIALYSIS	2,668	0	84,785	0	84,785	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	911	0	192,510	0	192,510	90.00
91.00	09100	EMERGENCY	12,334	0	1,005,499	0	1,005,499	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)				0		92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	244,752	247,504	16,427,172	0	16,427,172	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	78,848	0	78,848	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	131	0	272,385	0	272,385	192.00
194.00	07951	NONREIMBURSABLE DEPARTMENTS	0	0	1,866,461	0	1,866,461	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	244,883	247,504	18,644,866	0	18,644,866	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1

Date/Time Prepared:
4/10/2017 1:12 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQ FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	339,129				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		13,299,429			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	9,737	0	53,213,390		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	1,103,893	3,698,554	-28,639,701	117,729,683
6.00 00600	MAINTENANCE & REPAIRS	46,317	1,450	0	0	2,955,421
7.00 00700	OPERATION OF PLANT	15,090	7,966,682	956,685	0	8,392,111
8.00 00800	LAUNDRY & LINEN SERVICE	4,252	974	141,779	0	830,375
9.00 00900	HOUSEKEEPING	9,915	17,654	1,279,236	0	2,775,584
10.00 01000	DIETARY	3,828	11,534	414,348	0	731,801
11.00 01100	CAFETERIA	9,999	0	1,125,422	0	1,999,315
13.00 01300	NURSING ADMINISTRATION	1,897	372,892	874,479	0	1,497,545
14.00 01400	CENTRAL SERVICE & SUPPLY	0	50,551	316,294	0	852,597
15.00 01500	PHARMACY	3,378	21,692	1,978,120	0	3,138,041
16.00 01600	MEDICAL RECORDS & LIBRARY	4,054	1,944	618,128	0	1,175,906
17.00 01700	SOCIAL SERVICE	3,380	0	1,268,878	0	1,959,882
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	56,052	107,086	16,689,088	0	19,783,238
31.00 03100	INTENSIVE CARE UNIT	17,513	112,275	3,066,028	0	4,358,207
41.00 04100	SUBPROVIDER - IRF	9,028	0	881,393	0	1,436,600
43.00 04300	NURSERY	1,071	0	0	0	1,050,185
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	31,424	720,170	3,389,409	0	7,856,806
51.00 05100	RECOVERY ROOM	0	12,991	473,051	0	644,102
52.00 05200	DELIVERY ROOM & LABOR ROOM	9,660	0	0	0	1,093,360
53.00 05300	ANESTHESIOLOGY	256	30,378	0	0	179,286
54.00 05400	RADIOLOGY-DIAGNOSTIC	22,391	542,591	1,807,161	0	3,433,368
55.00 05500	RADIOLOGY - THERAPEUTIC	0	0	99,669	0	164,898
56.00 05600	RADIOISOTOPE	0	91,261	241,919	0	929,681
57.00 05700	CT SCAN	3,857	244,903	435,341	0	891,700
58.00 05800	MRI	2,171	12,032	232,259	0	390,870
59.00 05900	CARDIAC CATHETERIZATION	6,585	118,174	704,443	0	1,389,643
60.00 06000	LABORATORY	8,885	168,497	1,975,561	0	6,693,865
64.00 06400	INTRAVENOUS THERAPY	1,354	1,560	246,195	0	368,954
65.00 06500	RESPIRATORY THERAPY	1,472	89,858	1,293,309	0	1,935,185
66.00 06600	PHYSICAL THERAPY	3,740	6,180	1,198,454	0	1,747,194
66.01 06601	CLINICAL NUTRITION	0	0	180,029	0	258,234
67.00 06700	OCCUPATIONAL THERAPY	3,443	604	761,280	0	1,298,389
68.00 06800	SPEECH PATHOLOGY	681	0	286,235	0	406,451
69.00 06900	ELECTROCARDIOLOGY	17,520	101,165	487,191	0	1,390,926
69.01 06901	CARDIAC REHABILITATION	0	15,852	194,609	0	267,272
70.00 07000	ELECTROENCEPHALOGRAPHY	0	6,582	60,673	0	102,725
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	223,005	0	9,279,903
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	6,441,402
73.00 07300	DRUGS CHARGED TO PATIENTS	0	10,615	1,238,414	0	7,282,147
74.00 07400	RENAL DIALYSIS	0	5,634	24,226	0	559,879
76.00 03950	ACUTE DIALYSIS	1,060	37,410	161,215	0	298,028
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	2,162	101,812	483,497	0	939,498
91.00 09100	EMERGENCY	15,584	76,063	2,936,096	0	4,481,221
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	327,756	12,162,959	52,441,673	-28,639,701	113,661,795
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	1,423	1,052	84,522	0	166,952
192.00 19200	PHYSICIANS PRIVATE OFFICES	0	398,030	265,591	0	399,513
194.00 07951	NONREIMBURSABLE DEPARTMENTS	9,950	737,388	421,604	0	3,501,423
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	9,153,002	7,169,350	18,145,528		28,639,701
203.00	Unit cost multiplier (Wkst. B, Part I)	26.989735	0.539072	0.340996		0.243267
204.00	Cost to be allocated (per Wkst. B, Part II)			262,799		1,230,419
205.00	Unit cost multiplier (Wkst. B, Part II)			0.004939		0.010451

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1
Date/Time Prepared:
4/10/2017 1:12 pm

Cost Center Description		MAINTENANCE & REPAIRS (TIME SPENT)	OPERATION OF PLANT (SQ FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQ FEET)	DIETARY (MEALS SERVED)		
		6.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
6.00	00600	MAINTENANCE & REPAIRS	26,387,564				6.00	
7.00	00700	OPERATION OF PLANT	13,299,431	267,985			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,252	988,981		8.00	
9.00	00900	HOUSEKEEPING	1,103,893	9,915	4,945	253,817	9.00	
10.00	01000	DIETARY	1,450	3,828	1,863	3,828	178,037	10.00
11.00	01100	CAFETERIA	7,966,682	9,999	5,060	9,999	0	11.00
13.00	01300	NURSING ADMINISTRATION	974	1,897	0	1,897	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	17,654	0	0	0	0	14.00
15.00	01500	PHARMACY	11,534	3,378	0	3,378	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,054	0	4,054	0	16.00
17.00	01700	SOCIAL SERVICE	372,892	3,380	0	3,380	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,692	56,052	464,425	56,052	130,634	30.00
31.00	03100	INTENSIVE CARE UNIT	1,944	17,513	95,634	17,513	6,541	31.00
41.00	04100	SUBPROVIDER - I RF	0	9,028	49,449	9,028	7,341	41.00
43.00	04300	NURSERY	0	1,071	14,835	1,071	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	112,275	31,424	82,382	31,424	9,645	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,660	0	9,660	0	52.00
53.00	05300	ANESTHESIOLOGY	0	256	0	256	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	720,170	22,391	90,096	22,391	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	12,991	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	30,378	3,857	0	3,856	0	57.00
58.00	05800	MRI	542,591	2,171	19,780	2,171	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	6,585	9,890	6,585	0	59.00
60.00	06000	LABORATORY	91,261	8,885	0	8,885	0	60.00
64.00	06400	INTRAVENOUS THERAPY	244,903	1,354	0	1,354	0	64.00
65.00	06500	RESPIRATORY THERAPY	12,032	1,472	0	1,472	0	65.00
66.00	06600	PHYSICAL THERAPY	118,174	3,740	0	3,740	0	66.00
66.01	06601	CLINICAL NUTRITION	168,497	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	3,443	0	3,443	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,560	681	0	681	0	68.00
69.00	06900	ELECTROCARDIOLOGY	89,858	17,520	4,945	17,520	0	69.00
69.01	06901	CARDIAC REHABILITATION	6,180	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	2,472	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	604	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	101,165	0	31,944	0	0	73.00
74.00	07400	RENAL DIALYSIS	15,852	0	2,176	0	0	74.00
76.00	03950	ACUTE DIALYSIS	6,582	1,060	0	1,060	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,944	2,162	0	2,162	0	90.00
91.00	09100	EMERGENCY	76,063	15,584	102,162	15,584	2,676	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	25,154,226	256,612	982,058	242,444	156,837	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	1,052	1,423	0	1,423	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	494,898	0	0	0	0	192.00
194.00	07951	NONREIMBURSABLE DEPARTMENTS	737,388	9,950	6,923	9,950	21,200	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,674,377	12,285,528	1,227,307	4,065,187	1,149,139	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.139247	45.844088	1.240981	16.016212	6.454495	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,281,753	5,494,459	211,841	615,219	207,462	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.048574	20.502860	0.214201	2.423868	1.165275	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1
Date/Time Prepared:
4/10/2017 1:12 pm

Cost Center Description		CAFETERIA (FTE SERVICE)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (ADMINISTRATIVE CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	768					11.00
13.00	01300	12	1,574,657				13.00
14.00	01400	10	21,075	15,659,497			14.00
15.00	01500	24	50,464	12,992	5,379,913		15.00
16.00	01600	16	33,871	0	0	489,915,030	16.00
17.00	01700	21	42,659	71	3	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	267	555,445	1,292,106	38	40,818,066	30.00
31.00	03100	44	92,483	476,206	62	5,610,089	31.00
41.00	04100	15	31,690	3,922	0	2,096,354	41.00
43.00	04300	0	0	0	0	1,558,110	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	57	117,566	9,466,849	6,238	67,026,003	50.00
51.00	05100	6	12,869	34,326	0	10,450,447	51.00
52.00	05200	0	0	0	0	6,758,333	52.00
53.00	05300	0	0	271,496	1,410	12,005,238	53.00
54.00	05400	32	66,883	287,113	0	25,213,454	54.00
55.00	05500	2	4,211	0	0	0	55.00
56.00	05600	3	6,567	7,684	0	8,771,927	56.00
57.00	05700	8	16,399	65,877	0	43,940,039	57.00
58.00	05800	4	7,743	59,320	0	10,677,778	58.00
59.00	05900	9	18,611	2,471,238	0	25,097,726	59.00
60.00	06000	45	93,095	178,842	0	73,317,046	60.00
64.00	06400	4	8,069	0	0	1,705,408	64.00
65.00	06500	26	53,255	41,058	0	18,318,551	65.00
66.00	06600	20	41,969	176,554	2,459	6,942,792	66.00
66.01	06601	4	7,667	9,284	0	32,736	66.01
67.00	06700	13	26,731	0	0	2,811,288	67.00
68.00	06800	4	8,647	10,787	345	1,004,816	68.00
69.00	06900	10	21,521	3,054	0	15,676,472	69.00
69.01	06901	4	7,352	23,884	0	805,272	69.01
70.00	07000	1	2,422	1,383	0	230,601	70.00
71.00	07100	8	15,661	64	0	9,269,884	71.00
72.00	07200	0	0	0	0	19,851,512	72.00
73.00	07300	25	52,356	123,548	4,183,584	45,995,346	73.00
74.00	07400	0	70	8,902	0	1,842,206	74.00
76.00	03950	2	4,932	163,848	10	5,335,421	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	9	19,669	54,775	10,970	1,821,519	90.00
91.00	09100	49	102,356	413,139	62	24,667,646	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		754	1,544,308	15,658,322	4,205,181	489,652,080	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	3	6,984	510	0	0	190.00
192.00	19200	3	6,586	665	0	262,950	192.00
194.00	07951	8	16,779	0	1,174,732	0	194.00
200.00							200.00
201.00							201.00
202.00		4,219,839	2,045,268	1,144,784	4,310,359	1,844,654	202.00
203.00		5,494.582031	1.298866	0.073105	0.801195	0.003765	203.00
204.00		913,625	330,000	133,205	481,477	244,883	204.00
205.00		1,189.615885	0.209569	0.008506	0.089495	0.000500	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0046

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

Worksheet B-1
Date/Time Prepared:
4/10/2017 1:12 pm

Cost Center Description		SOCIAL SERVICE	
		(TIME SPENT)	
		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
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
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
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
66.01	06601	CLINICAL NUTRITION	66.01
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
69.01	06901	CARDIAC REHABILITATION	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03950	ACUTE DIALYSIS	76.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	92.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
194.00	07951	NONREIMBURSABLE DEPARTMENTS	194.00
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)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 4/10/2017 1:12 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		34,274,553	0	34,274,553	30.00
31.00	03100 INTENSIVE CARE UNIT		7,367,662	5,264	7,372,926	31.00
41.00	04100 SUBPROVIDER - I RF		2,814,536	3,183	2,817,719	41.00
43.00	04300 NURSERY		1,396,188	0	1,396,188	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		13,307,441	0	13,307,441	50.00
51.00	05100 RECOVERY ROOM		892,328	0	892,328	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,982,354	0	1,982,354	52.00
53.00	05300 ANESTHESIOLOGY		304,914	42,190	347,104	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		6,244,413	0	6,244,413	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC		223,280	0	223,280	55.00
56.00	05600 RADIOISOTOPE		1,214,444	0	1,214,444	56.00
57.00	05700 CT SCAN		1,586,938	0	1,586,938	57.00
58.00	05800 MRI		796,930	0	796,930	58.00
59.00	05900 CARDIAC CATHETERIZATION		2,496,097	0	2,496,097	59.00
60.00	06000 LABORATORY		9,542,009	30,005	9,572,014	60.00
64.00	06400 INTRAVENOUS THERAPY		615,449	0	615,449	64.00
65.00	06500 RESPIRATORY THERAPY	0	2,782,686	3,790	2,786,476	65.00
66.00	06600 PHYSICAL THERAPY	0	2,625,463	0	2,625,463	66.00
66.01	06601 CLINICAL NUTRITION	0	377,255	0	377,255	66.01
67.00	06700 OCCUPATIONAL THERAPY	0	1,943,963	7,667	1,951,630	67.00
68.00	06800 SPEECH PATHOLOGY	0	585,728	0	585,728	68.00
69.00	06900 ELECTROCARDIOLOGY		2,973,877	50,752	3,024,629	69.00
69.01	06901 CARDIAC REHABILITATION		369,456	9,325	378,781	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY		140,393	2,364	142,757	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT		11,636,686	0	11,636,686	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		8,083,124	0	8,083,124	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		12,846,821	0	12,846,821	73.00
74.00	07400 RENAL DIALYSIS		708,664	13,240	721,904	74.00
76.00	03950 ACUTE DIALYSIS		486,486	0	486,486	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		1,397,126	0	1,397,126	90.00
91.00	09100 EMERGENCY		7,215,339	0	7,215,339	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)		4,062,932		4,062,932	92.00
200.00	Subtotal (see instructions)	0	143,295,535	167,780	143,463,315	200.00
201.00	Less Observation Beds		4,062,932		4,062,932	201.00
202.00	Total (see instructions)	0	139,232,603	167,780	139,400,383	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 4/10/2017 1:12 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	40,818,066		40,818,066	30.00
31.00	03100	INTENSIVE CARE UNIT	5,610,089		5,610,089	31.00
41.00	04100	SUBPROVIDER - IRF	2,096,354		2,096,354	41.00
43.00	04300	NURSERY	1,558,110		1,558,110	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,441,613	31,584,390	67,026,003	0.198541 50.00
51.00	05100	RECOVERY ROOM	4,967,887	5,482,560	10,450,447	0.085387 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,342,456	2,415,877	6,758,333	0.293320 52.00
53.00	05300	ANESTHESIOLOGY	5,780,931	6,224,307	12,005,238	0.025398 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,941,826	18,649,001	25,590,827	0.244010 54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0.000000 55.00
56.00	05600	RADIOISOTOPE	1,915,140	6,856,787	8,771,927	0.138447 56.00
57.00	05700	CT SCAN	12,234,595	31,705,444	43,940,039	0.036116 57.00
58.00	05800	MRI	1,699,173	8,978,605	10,677,778	0.074634 58.00
59.00	05900	CARDIAC CATHETERIZATION	13,561,492	11,536,234	25,097,726	0.099455 59.00
60.00	06000	LABORATORY	34,229,996	39,014,249	73,244,245	0.130277 60.00
64.00	06400	INTRAVENOUS THERAPY	9,758	1,695,650	1,705,408	0.360881 64.00
65.00	06500	RESPIRATORY THERAPY	16,193,117	2,125,434	18,318,551	0.151905 65.00
66.00	06600	PHYSICAL THERAPY	4,800,277	2,142,515	6,942,792	0.378157 66.00
66.01	06601	CLINICAL NUTRITION	528	32,208	32,736	11.524163 66.01
67.00	06700	OCCUPATIONAL THERAPY	2,139,674	671,614	2,811,288	0.691485 67.00
68.00	06800	SPEECH PATHOLOGY	348,061	656,755	1,004,816	0.582921 68.00
69.00	06900	ELECTROCARDIOLOGY	6,915,633	8,760,839	15,676,472	0.189703 69.00
69.01	06901	CARDIAC REHABILITATION	140,442	664,830	805,272	0.458797 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	157,798	72,803	230,601	0.608813 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	5,612,614	3,657,271	9,269,885	1.255322 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	13,357,349	6,494,165	19,851,514	0.407179 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,931,473	16,063,876	45,995,349	0.279307 73.00
74.00	07400	RENAL DIALYSIS	1,842,206	0	1,842,206	0.384682 74.00
76.00	03950	ACUTE DIALYSIS	897,371	4,438,050	5,335,421	0.091180 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	22,674	1,798,845	1,821,519	0.767011 90.00
91.00	09100	EMERGENCY	5,859,034	18,808,612	24,667,646	0.292502 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	387,128	3,092,184	3,479,312	1.167740 92.00
200.00		Subtotal (see instructions)	259,812,865	233,623,105	493,435,970	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	259,812,865	233,623,105	493,435,970	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 4/10/2017 1:12 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
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.198541		50.00
51.00	05100 RECOVERY ROOM	0.085387		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.293320		52.00
53.00	05300 ANESTHESIOLOGY	0.028913		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.244010		54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.000000		55.00
56.00	05600 RADIOISOTOPE	0.138447		56.00
57.00	05700 CT SCAN	0.036116		57.00
58.00	05800 MRI	0.074634		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.099455		59.00
60.00	06000 LABORATORY	0.130686		60.00
64.00	06400 INTRAVENOUS THERAPY	0.360881		64.00
65.00	06500 RESPIRATORY THERAPY	0.152112		65.00
66.00	06600 PHYSICAL THERAPY	0.378157		66.00
66.01	06601 CLINICAL NUTRITION	11.524163		66.01
67.00	06700 OCCUPATIONAL THERAPY	0.694212		67.00
68.00	06800 SPEECH PATHOLOGY	0.582921		68.00
69.00	06900 ELECTROCARDIOLOGY	0.192941		69.00
69.01	06901 CARDIAC REHABILITATION	0.470376		69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.619065		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1.255322		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.407179		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.279307		73.00
74.00	07400 RENAL DIALYSIS	0.391869		74.00
76.00	03950 ACUTE DIALYSIS	0.091180		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.767011		90.00
91.00	09100 EMERGENCY	0.292502		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.167740		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0046

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

Worksheet C
Part I
Date/Time Prepared:
4/10/2017 1:12 pm

		Title XIX		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	34,274,553		34,274,553	0	34,274,553	30.00
31.00	03100 INTENSIVE CARE UNIT	7,367,662		7,367,662	5,264	7,372,926	31.00
41.00	04100 SUBPROVIDER - I RF	2,814,536		2,814,536	3,183	2,817,719	41.00
43.00	04300 NURSERY	1,396,188		1,396,188	0	1,396,188	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	13,307,441		13,307,441	0	13,307,441	50.00
51.00	05100 RECOVERY ROOM	892,328		892,328	0	892,328	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,982,354		1,982,354	0	1,982,354	52.00
53.00	05300 ANESTHESIOLOGY	304,914		304,914	42,190	347,104	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,244,413		6,244,413	0	6,244,413	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	223,280		223,280	0	223,280	55.00
56.00	05600 RADIOISOTOPE	1,214,444		1,214,444	0	1,214,444	56.00
57.00	05700 CT SCAN	1,586,938		1,586,938	0	1,586,938	57.00
58.00	05800 MRI	796,930		796,930	0	796,930	58.00
59.00	05900 CARDIAC CATHETERIZATION	2,496,097		2,496,097	0	2,496,097	59.00
60.00	06000 LABORATORY	9,542,009		9,542,009	30,005	9,572,014	60.00
64.00	06400 INTRAVENOUS THERAPY	615,449		615,449	0	615,449	64.00
65.00	06500 RESPIRATORY THERAPY	2,782,686	0	2,782,686	3,790	2,786,476	65.00
66.00	06600 PHYSICAL THERAPY	2,625,463	0	2,625,463	0	2,625,463	66.00
66.01	06601 CLINICAL NUTRITION	377,255	0	377,255	0	377,255	66.01
67.00	06700 OCCUPATIONAL THERAPY	1,943,963	0	1,943,963	7,667	1,951,630	67.00
68.00	06800 SPEECH PATHOLOGY	585,728	0	585,728	0	585,728	68.00
69.00	06900 ELECTROCARDIOLOGY	2,973,877		2,973,877	50,752	3,024,629	69.00
69.01	06901 CARDIAC REHABILITATION	369,456		369,456	9,325	378,781	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	140,393		140,393	2,364	142,757	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	11,636,686		11,636,686	0	11,636,686	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	8,083,124		8,083,124	0	8,083,124	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	12,846,821		12,846,821	0	12,846,821	73.00
74.00	07400 RENAL DIALYSIS	708,664		708,664	13,240	721,904	74.00
76.00	03950 ACUTE DIALYSIS	486,486		486,486	0	486,486	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1,397,126		1,397,126	0	1,397,126	90.00
91.00	09100 EMERGENCY	7,215,339		7,215,339	0	7,215,339	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	4,062,932		4,062,932		4,062,932	92.00
200.00	Subtotal (see instructions)	143,295,535	0	143,295,535	167,780	143,463,315	200.00
201.00	Less Observation Beds	4,062,932		4,062,932		4,062,932	201.00
202.00	Total (see instructions)	139,232,603	0	139,232,603	167,780	139,400,383	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0046

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

Worksheet C
Part I
Date/Time Prepared:
4/10/2017 1:12 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS	
		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	40,818,066		40,818,066			30.00
31.00	03100	INTENSIVE CARE UNIT	5,610,089		5,610,089			31.00
41.00	04100	SUBPROVIDER - IRF	2,096,354		2,096,354			41.00
43.00	04300	NURSERY	1,558,110		1,558,110			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	35,441,613	31,584,390	67,026,003	0.198541	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,967,887	5,482,560	10,450,447	0.085387	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,342,456	2,415,877	6,758,333	0.293320	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	5,780,931	6,224,307	12,005,238	0.025398	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,941,826	18,649,001	25,590,827	0.244010	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
56.00	05600	RADIOISOTOPE	1,915,140	6,856,787	8,771,927	0.138447	0.000000	56.00
57.00	05700	CT SCAN	12,234,595	31,705,444	43,940,039	0.036116	0.000000	57.00
58.00	05800	MRI	1,699,173	8,978,605	10,677,778	0.074634	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	13,561,492	11,536,234	25,097,726	0.099455	0.000000	59.00
60.00	06000	LABORATORY	34,229,996	39,014,249	73,244,245	0.130277	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	9,758	1,695,650	1,705,408	0.360881	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	16,193,117	2,125,434	18,318,551	0.151905	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,800,277	2,142,515	6,942,792	0.378157	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	528	32,208	32,736	11.524163	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	2,139,674	671,614	2,811,288	0.691485	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	348,061	656,755	1,004,816	0.582921	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	6,915,633	8,760,839	15,676,472	0.189703	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	140,442	664,830	805,272	0.458797	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	157,798	72,803	230,601	0.608813	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	5,612,614	3,657,271	9,269,885	1.255322	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	13,357,349	6,494,165	19,851,514	0.407179	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,931,473	16,063,876	45,995,349	0.279307	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,842,206	0	1,842,206	0.384682	0.000000	74.00
76.00	03950	ACUTE DIALYSIS	897,371	4,438,050	5,335,421	0.091180	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	22,674	1,798,845	1,821,519	0.767011	0.000000	90.00
91.00	09100	EMERGENCY	5,859,034	18,808,612	24,667,646	0.292502	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	387,128	3,092,184	3,479,312	1.167740	0.000000	92.00
200.00		Subtotal (see instructions)	259,812,865	233,623,105	493,435,970			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	259,812,865	233,623,105	493,435,970			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 4/10/2017 1:12 pm
		Title XIX	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
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.198541		50.00
51.00	05100 RECOVERY ROOM	0.085387		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.293320		52.00
53.00	05300 ANESTHESIOLOGY	0.028913		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.244010		54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.000000		55.00
56.00	05600 RADIOISOTOPE	0.138447		56.00
57.00	05700 CT SCAN	0.036116		57.00
58.00	05800 MRI	0.074634		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.099455		59.00
60.00	06000 LABORATORY	0.130686		60.00
64.00	06400 INTRAVENOUS THERAPY	0.360881		64.00
65.00	06500 RESPIRATORY THERAPY	0.152112		65.00
66.00	06600 PHYSICAL THERAPY	0.378157		66.00
66.01	06601 CLINICAL NUTRITION	11.524163		66.01
67.00	06700 OCCUPATIONAL THERAPY	0.694212		67.00
68.00	06800 SPEECH PATHOLOGY	0.582921		68.00
69.00	06900 ELECTROCARDIOLOGY	0.192941		69.00
69.01	06901 CARDIAC REHABILITATION	0.470376		69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.619065		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1.255322		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.407179		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.279307		73.00
74.00	07400 RENAL DIALYSIS	0.391869		74.00
76.00	03950 ACUTE DIALYSIS	0.091180		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.767011		90.00
91.00	09100 EMERGENCY	0.292502		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.167740		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 14-0046

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

Worksheet C
Part II
Date/Time Prepared:
4/10/2017 1:12 pm

Cost Center Description			Title XIX			Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,307,441	2,678,160	10,629,281	0	0	50.00
51.00	05100	RECOVERY ROOM	892,328	31,423	860,905	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,982,354	497,000	1,485,354	0	0	52.00
53.00	05300	ANESTHESIOLOGY	304,914	42,137	262,777	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,244,413	1,598,189	4,646,224	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	223,280	28,600	194,680	0	0	55.00
56.00	05600	RADIOISOTOPE	1,214,444	69,503	1,144,941	0	0	56.00
57.00	05700	CT SCAN	1,586,938	372,974	1,213,964	0	0	57.00
58.00	05800	MRI	796,930	162,905	634,025	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,496,097	460,699	2,035,398	0	0	59.00
60.00	06000	LABORATORY	9,542,009	729,964	8,812,045	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	615,449	92,698	522,751	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,782,686	239,086	2,543,600	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,625,463	259,866	2,365,597	0	0	66.00
66.01	06601	CLINICAL NUTRITION	377,255	18,233	359,022	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	1,943,963	211,990	1,731,973	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	585,728	46,968	538,760	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,973,877	976,621	1,997,256	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	369,456	19,504	349,952	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	140,393	14,039	126,354	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	11,636,686	115,549	11,521,137	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	8,083,124	77,245	8,005,879	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,846,821	538,873	12,307,948	0	0	73.00
74.00	07400	RENAL DIALYSIS	708,664	11,256	697,408	0	0	74.00
76.00	03950	ACUTE DIALYSIS	486,486	84,785	401,701	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,397,126	192,510	1,204,616	0	0	90.00
91.00	09100	EMERGENCY	7,215,339	1,005,499	6,209,840	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	4,062,932	487,873	3,575,059	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	97,442,596	11,064,149	86,378,447	0	0	200.00
201.00		Less Observation Beds	4,062,932	487,873	3,575,059	0	0	201.00
202.00		Total (line 200 minus line 201)	93,379,664	10,576,276	82,803,388	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part II Date/Time Prepared: 4/10/2017 1:12 pm
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Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
Title XIX Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	13,307,441	67,026,003	0.198541	50.00
51.00	05100 RECOVERY ROOM	892,328	10,450,447	0.085387	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,982,354	6,758,333	0.293320	52.00
53.00	05300 ANESTHESIOLOGY	304,914	12,005,238	0.025398	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,244,413	25,590,827	0.244010	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	223,280	0	0.000000	55.00
56.00	05600 RADIOISOTOPE	1,214,444	8,771,927	0.138447	56.00
57.00	05700 CT SCAN	1,586,938	43,940,039	0.036116	57.00
58.00	05800 MRI	796,930	10,677,778	0.074634	58.00
59.00	05900 CARDIAC CATHETERIZATION	2,496,097	25,097,726	0.099455	59.00
60.00	06000 LABORATORY	9,542,009	73,244,245	0.130277	60.00
64.00	06400 INTRAVENOUS THERAPY	615,449	1,705,408	0.360881	64.00
65.00	06500 RESPIRATORY THERAPY	2,782,686	18,318,551	0.151905	65.00
66.00	06600 PHYSICAL THERAPY	2,625,463	6,942,792	0.378157	66.00
66.01	06601 CLINICAL NUTRITION	377,255	32,736	11.524163	66.01
67.00	06700 OCCUPATIONAL THERAPY	1,943,963	2,811,288	0.691485	67.00
68.00	06800 SPEECH PATHOLOGY	585,728	1,004,816	0.582921	68.00
69.00	06900 ELECTROCARDIOLOGY	2,973,877	15,676,472	0.189703	69.00
69.01	06901 CARDIAC REHABILITATION	369,456	805,272	0.458797	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	140,393	230,601	0.608813	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	11,636,686	9,269,885	1.255322	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	8,083,124	19,851,514	0.407179	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	12,846,821	45,995,349	0.279307	73.00
74.00	07400 RENAL DIALYSIS	708,664	1,842,206	0.384682	74.00
76.00	03950 ACUTE DIALYSIS	486,486	5,335,421	0.091180	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	1,397,126	1,821,519	0.767011	90.00
91.00	09100 EMERGENCY	7,215,339	24,667,646	0.292502	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	4,062,932	3,479,312	1.167740	92.00
200.00	Subtotal (sum of lines 50 thru 199)	97,442,596	443,353,351		200.00
201.00	Less Observation Beds	4,062,932	0		201.00
202.00	Total (line 200 minus line 201)	93,379,664	443,353,351		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0046		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part I Date/Time Prepared: 4/10/2017 1:12 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	Per Diem (col. 3 / col. 4)	PPS
Title XVIII		Hospital		PPS			
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	4,115,639	0	4,115,639	28,640	143.70	30.00
31.00	INTENSIVE CARE UNIT	1,132,339		1,132,339	2,749	411.91	31.00
41.00	SUBPROVIDER - IRF	534,525	0	534,525	2,195	243.52	41.00
43.00	NURSERY	68,393		68,393	1,794	38.12	43.00
200.00	Total (lines 30-199)	5,850,896		5,850,896	35,378		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	14,455	2,077,184				
31.00	INTENSIVE CARE UNIT	1,123	462,575				
41.00	SUBPROVIDER - IRF	1,641	399,616				
43.00	NURSERY	0	0				
200.00	Total (lines 30-199)	17,219	2,939,375				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Prepared: 4/10/2017 1:12 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	2,678,160	67,026,003	0.039957	24,915,062	995,531	50.00
51.00	05100	RECOVERY ROOM	31,423	10,450,447	0.003007	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	497,000	6,758,333	0.073539	1,603	118	52.00
53.00	05300	ANESTHESIOLOGY	42,137	12,005,238	0.003510	1,960,289	6,881	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,598,189	25,590,827	0.062452	5,274,946	329,431	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	28,600	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	69,503	8,771,927	0.007923	0	0	56.00
57.00	05700	CT SCAN	372,974	43,940,039	0.008488	6,324,625	53,683	57.00
58.00	05800	MRI	162,905	10,677,778	0.015256	760,603	11,604	58.00
59.00	05900	CARDIAC CATHETERIZATION	460,699	25,097,726	0.018356	5,481,264	100,614	59.00
60.00	06000	LABORATORY	729,964	73,244,245	0.009966	18,078,850	180,174	60.00
64.00	06400	INTRAVENOUS THERAPY	92,698	1,705,408	0.054355	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	239,086	18,318,551	0.013052	9,361,855	122,191	65.00
66.00	06600	PHYSICAL THERAPY	259,866	6,942,792	0.037430	2,374,377	88,873	66.00
66.01	06601	CLINICAL NUTRITION	18,233	32,736	0.556971	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	211,990	2,811,288	0.075407	530,399	39,996	67.00
68.00	06800	SPEECH PATHOLOGY	46,968	1,004,816	0.046743	141,166	6,599	68.00
69.00	06900	ELECTROCARDIOLOGY	976,621	15,676,472	0.062299	4,128,938	257,229	69.00
69.01	06901	CARDIAC REHABILITATION	19,504	805,272	0.024220	77,163	1,869	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	14,039	230,601	0.060880	87,208	5,309	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	115,549	9,269,885	0.012465	3,196,507	39,844	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	77,245	19,851,514	0.003891	7,146,494	27,807	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	538,873	45,995,349	0.011716	16,013,028	187,609	73.00
74.00	07400	RENAL DIALYSIS	11,256	1,842,206	0.006110	1,254,926	7,668	74.00
76.00	03950	ACUTE DIALYSIS	84,785	5,335,421	0.015891	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	192,510	1,821,519	0.105687	0	0	90.00
91.00	09100	EMERGENCY	1,005,499	24,667,646	0.040762	3,426,426	139,668	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	487,873	3,479,312	0.140221	230,020	32,254	92.00
200.00		Total (lines 50-199)	11,064,149	443,353,351		110,765,749	2,634,952	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0046		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part III Date/Time Prepared: 4/10/2017 1:12 pm	
Title XVIII			Hospital			PPS		
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
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	28,640	0.00	14,455	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,749	0.00	1,123	0		31.00
41.00	04100	SUBPROVIDER - IRF	2,195	0.00	1,641	0		41.00
43.00	04300	NURSERY	1,794	0.00	0	0		43.00
200.00		Total (lines 30-199)	35,378		17,219	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 4/10/2017 1:12 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	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0	66.01
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
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	ACUTE DIALYSIS	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
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: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 4/10/2017 1:12 pm
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Cost Center Description		Title XVIII			Hospital		PPS	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	67,026,003	0.000000	0.000000	24,915,062	50.00
51.00	05100	RECOVERY ROOM	0	10,450,447	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,758,333	0.000000	0.000000	1,603	52.00
53.00	05300	ANESTHESIOLOGY	0	12,005,238	0.000000	0.000000	1,960,289	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	25,590,827	0.000000	0.000000	5,274,946	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	8,771,927	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	43,940,039	0.000000	0.000000	6,324,625	57.00
58.00	05800	MRI	0	10,677,778	0.000000	0.000000	760,603	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	25,097,726	0.000000	0.000000	5,481,264	59.00
60.00	06000	LABORATORY	0	73,244,245	0.000000	0.000000	18,078,850	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,705,408	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	18,318,551	0.000000	0.000000	9,361,855	65.00
66.00	06600	PHYSICAL THERAPY	0	6,942,792	0.000000	0.000000	2,374,377	66.00
66.01	06601	CLINICAL NUTRITION	0	32,736	0.000000	0.000000	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	2,811,288	0.000000	0.000000	530,399	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,004,816	0.000000	0.000000	141,166	68.00
69.00	06900	ELECTROCARDIOLOGY	0	15,676,472	0.000000	0.000000	4,128,938	69.00
69.01	06901	CARDIAC REHABILITATION	0	805,272	0.000000	0.000000	77,163	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	230,601	0.000000	0.000000	87,208	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	9,269,885	0.000000	0.000000	3,196,507	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	19,851,514	0.000000	0.000000	7,146,494	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	45,995,349	0.000000	0.000000	16,013,028	73.00
74.00	07400	RENAL DIALYSIS	0	1,842,206	0.000000	0.000000	1,254,926	74.00
76.00	03950	ACUTE DIALYSIS	0	5,335,421	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,821,519	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	24,667,646	0.000000	0.000000	3,426,426	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	3,479,312	0.000000	0.000000	230,020	92.00
200.00		Total (lines 50-199)	0	443,353,351			110,765,749	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 4/10/2017 1:12 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	17,506,581	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	1,899,062	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	9,187,874	0		54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	0		55.00
56.00	05600 RADIOISOTOPE	0	0	0		56.00
57.00	05700 CT SCAN	0	10,446,435	0		57.00
58.00	05800 MRI	0	2,938,281	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	4,390,202	0		59.00
60.00	06000 LABORATORY	0	8,806,976	0		60.00
64.00	06400 INTRAVENOUS THERAPY	0	134,328	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	483,902	0		65.00
66.00	06600 PHYSICAL THERAPY	0	82,910	0		66.00
66.01	06601 CLINICAL NUTRITION	0	0	0		66.01
67.00	06700 OCCUPATIONAL THERAPY	0	17,208	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	5,868	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	3,484,970	0		69.00
69.01	06901 CARDIAC REHABILITATION	0	320,934	0		69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	35,376	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	1,985,204	0		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	3,627,606	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6,942,206	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
76.00	03950 ACUTE DIALYSIS	0	134,230	0		76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	178,166	0		90.00
91.00	09100 EMERGENCY	0	6,077,225	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	1,276,691	0		92.00
200.00	Total (lines 50-199)	0	79,962,235	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 4/10/2017 1:12 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	0.198541	17,506,581	0	0	3,475,774	50.00
51.00	05100	RECOVERY ROOM	0.085387	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.293320	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.025398	1,899,062	0	0	48,232	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.244010	9,187,874	0	0	2,241,933	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.138447	0	0	0	0	56.00
57.00	05700	CT SCAN	0.036116	10,446,435	0	0	377,283	57.00
58.00	05800	MRI	0.074634	2,938,281	0	0	219,296	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.099455	4,390,202	0	0	436,628	59.00
60.00	06000	LABORATORY	0.130277	8,806,976	4,888	0	1,147,346	60.00
64.00	06400	INTRAVENOUS THERAPY	0.360881	134,328	0	0	48,476	64.00
65.00	06500	RESPIRATORY THERAPY	0.151905	483,902	0	0	73,507	65.00
66.00	06600	PHYSICAL THERAPY	0.378157	82,910	0	0	31,353	66.00
66.01	06601	CLINICAL NUTRITION	11.524163	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.691485	17,208	0	0	11,899	67.00
68.00	06800	SPEECH PATHOLOGY	0.582921	5,868	0	0	3,421	68.00
69.00	06900	ELECTROCARDIOLOGY	0.189703	3,484,970	0	0	661,109	69.00
69.01	06901	CARDIAC REHABILITATION	0.458797	320,934	0	0	147,244	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.608813	35,376	0	0	21,537	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.255322	1,985,204	0	0	2,492,070	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.407179	3,627,606	0	0	1,477,085	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.279307	6,942,206	39	300,706	1,939,007	73.00
74.00	07400	RENAL DIALYSIS	0.384682	0	0	0	0	74.00
76.00	03950	ACUTE DIALYSIS	0.091180	134,230	0	0	12,239	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.767011	178,166	0	0	136,655	90.00
91.00	09100	EMERGENCY	0.292502	6,077,225	0	0	1,777,600	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	1.167740	1,276,691	0	0	1,490,843	92.00
200.00		Subtotal (see instructions)		79,962,235	4,927	300,706	18,270,537	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		79,962,235	4,927	300,706	18,270,537	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 4/10/2017 1:12 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
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0		55.00
56.00 05600 RADIOISOTOPE	0	0		56.00
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	637	0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
66.01 06601 CLINICAL NUTRITION	0	0		66.01
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
69.01 06901 CARDIAC REHABILITATION	0	0		69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	11	83,989		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03950 ACUTE DIALYSIS	0	0		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT)	0	0		92.00
200.00 Subtotal (see instructions)	648	83,989		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	648	83,989		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part II Date/Time Prepared: 4/10/2017 1:12 pm	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,678,160	67,026,003	0.039957	10,980	439	50.00
51.00	05100	RECOVERY ROOM	31,423	10,450,447	0.003007	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	497,000	6,758,333	0.073539	0	0	52.00
53.00	05300	ANESTHESIOLOGY	42,137	12,005,238	0.003510	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,598,189	25,590,827	0.062452	14,926	932	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	28,600	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	69,503	8,771,927	0.007923	0	0	56.00
57.00	05700	CT SCAN	372,974	43,940,039	0.008488	5,400	46	57.00
58.00	05800	MRI	162,905	10,677,778	0.015256	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	460,699	25,097,726	0.018356	0	0	59.00
60.00	06000	LABORATORY	729,964	73,244,245	0.009966	109,728	1,094	60.00
64.00	06400	INTRAVENOUS THERAPY	92,698	1,705,408	0.054355	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	239,086	18,318,551	0.013052	243,996	3,185	65.00
66.00	06600	PHYSICAL THERAPY	259,866	6,942,792	0.037430	937,865	35,104	66.00
66.01	06601	CLINICAL NUTRITION	18,233	32,736	0.556971	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	211,990	2,811,288	0.075407	936,505	70,619	67.00
68.00	06800	SPEECH PATHOLOGY	46,968	1,004,816	0.046743	81,726	3,820	68.00
69.00	06900	ELECTROCARDIOLOGY	976,621	15,676,472	0.062299	10,334	644	69.00
69.01	06901	CARDIAC REHABILITATION	19,504	805,272	0.024220	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	14,039	230,601	0.060880	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	115,549	9,269,885	0.012465	20,419	255	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	77,245	19,851,514	0.003891	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	538,873	45,995,349	0.011716	279,575	3,276	73.00
74.00	07400	RENAL DIALYSIS	11,256	1,842,206	0.006110	0	0	74.00
76.00	03950	ACUTE DIALYSIS	84,785	5,335,421	0.015891	46,543	740	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	192,510	1,821,519	0.105687	0	0	90.00
91.00	09100	EMERGENCY	1,005,499	24,667,646	0.040762	154,605	6,302	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	3,479,312	0.000000	0	0	92.00
200.00		Total (lines 50-199)	10,576,276	443,353,351		2,852,602	126,456	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 4/10/2017 1:12 pm
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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	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
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
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601 CLINICAL NUTRITION	0	0	0	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901 CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950 ACUTE DIALYSIS	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	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: 14-0046 Component CCN: 14-T046	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 4/10/2017 1:12 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 ÷ col. 7)	Ratio of Cost to Charges (col. 6 ÷ col. 7)	
	6.00	7.00	8.00	9.00	10.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	67,026,003	0.000000	0.000000	10,980 50.00
51.00 05100 RECOVERY ROOM	0	10,450,447	0.000000	0.000000	0 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	6,758,333	0.000000	0.000000	0 52.00
53.00 05300 ANESTHESIOLOGY	0	12,005,238	0.000000	0.000000	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	25,590,827	0.000000	0.000000	14,926 54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	0.000000	0.000000	0 55.00
56.00 05600 RADIOISOTOPE	0	8,771,927	0.000000	0.000000	0 56.00
57.00 05700 CT SCAN	0	43,940,039	0.000000	0.000000	5,400 57.00
58.00 05800 MRI	0	10,677,778	0.000000	0.000000	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0	25,097,726	0.000000	0.000000	0 59.00
60.00 06000 LABORATORY	0	73,244,245	0.000000	0.000000	109,728 60.00
64.00 06400 INTRAVENOUS THERAPY	0	1,705,408	0.000000	0.000000	0 64.00
65.00 06500 RESPIRATORY THERAPY	0	18,318,551	0.000000	0.000000	243,996 65.00
66.00 06600 PHYSICAL THERAPY	0	6,942,792	0.000000	0.000000	937,865 66.00
66.01 06601 CLINICAL NUTRITION	0	32,736	0.000000	0.000000	0 66.01
67.00 06700 OCCUPATIONAL THERAPY	0	2,811,288	0.000000	0.000000	936,505 67.00
68.00 06800 SPEECH PATHOLOGY	0	1,004,816	0.000000	0.000000	81,726 68.00
69.00 06900 ELECTROCARDIOLOGY	0	15,676,472	0.000000	0.000000	10,334 69.00
69.01 06901 CARDIAC REHABILITATION	0	805,272	0.000000	0.000000	0 69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	230,601	0.000000	0.000000	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	9,269,885	0.000000	0.000000	20,419 71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	19,851,514	0.000000	0.000000	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	45,995,349	0.000000	0.000000	279,575 73.00
74.00 07400 RENAL DIALYSIS	0	1,842,206	0.000000	0.000000	0 74.00
76.00 03950 ACUTE DIALYSIS	0	5,335,421	0.000000	0.000000	46,543 76.00
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	1,821,519	0.000000	0.000000	0 90.00
91.00 09100 EMERGENCY	0	24,667,646	0.000000	0.000000	154,605 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT)	0	3,479,312	0.000000	0.000000	0 92.00
200.00 Total (lines 50-199)	0	443,353,351			2,852,602 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 4/10/2017 1:12 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	56.00
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
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
66.01	06601 CLINICAL NUTRITION	0	0	0	66.01
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
69.01	06901 CARDIAC REHABILITATION	0	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.00	03950 ACUTE DIALYSIS	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part I Date/Time Prepared: 4/10/2017 1:12 pm
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Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	4,115,639	0	4,115,639	28,640	143.70	30.00	
31.00	INTENSIVE CARE UNIT	1,132,339		1,132,339	2,749	411.91	31.00	
41.00	SUBPROVIDER - IRF	534,525	0	534,525	2,195	243.52	41.00	
43.00	NURSERY	68,393		68,393	1,794	38.12	43.00	
200.00	Total (Lines 30-199)	5,850,896		5,850,896	35,378		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	4,108	590,320					30.00
31.00	INTENSIVE CARE UNIT	467	192,362					31.00
41.00	SUBPROVIDER - IRF	283	68,916					41.00
43.00	NURSERY	1,265	48,222					43.00
200.00	Total (Lines 30-199)	6,123	899,820					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Prepared: 4/10/2017 1:12 pm
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Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,678,160	67,026,003	0.039957	0	0	50.00
51.00	05100	RECOVERY ROOM	31,423	10,450,447	0.003007	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	497,000	6,758,333	0.073539	0	0	52.00
53.00	05300	ANESTHESIOLOGY	42,137	12,005,238	0.003510	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,598,189	25,590,827	0.062452	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	28,600	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	69,503	8,771,927	0.007923	0	0	56.00
57.00	05700	CT SCAN	372,974	43,940,039	0.008488	0	0	57.00
58.00	05800	MRI	162,905	10,677,778	0.015256	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	460,699	25,097,726	0.018356	0	0	59.00
60.00	06000	LABORATORY	729,964	73,244,245	0.009966	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	92,698	1,705,408	0.054355	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	239,086	18,318,551	0.013052	0	0	65.00
66.00	06600	PHYSICAL THERAPY	259,866	6,942,792	0.037430	0	0	66.00
66.01	06601	CLINICAL NUTRITION	18,233	32,736	0.556971	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	211,990	2,811,288	0.075407	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	46,968	1,004,816	0.046743	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	976,621	15,676,472	0.062299	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	19,504	805,272	0.024220	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	14,039	230,601	0.060880	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	115,549	9,269,885	0.012465	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	77,245	19,851,514	0.003891	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	538,873	45,995,349	0.011716	0	0	73.00
74.00	07400	RENAL DIALYSIS	11,256	1,842,206	0.006110	0	0	74.00
76.00	03950	ACUTE DIALYSIS	84,785	5,335,421	0.015891	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	192,510	1,821,519	0.105687	0	0	90.00
91.00	09100	EMERGENCY	1,005,499	24,667,646	0.040762	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	487,873	3,479,312	0.140221	0	0	92.00
200.00		Total (lines 50-199)	11,064,149	443,353,351		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0046		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part III Date/Time Prepared: 4/10/2017 1:12 pm	
Cost Center Description			Title XIX			Hospital		PPS
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
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	28,640	0.00	4,108	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,749	0.00	467	0		31.00
41.00	04100	SUBPROVIDER - IRF	2,195	0.00	283	0		41.00
43.00	04300	NURSERY	1,794	0.00	1,265	0		43.00
200.00		Total (lines 30-199)	35,378		6,123	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 4/10/2017 1:12 pm
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Cost Center Description	Title XIX			Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0	66.01
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
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	ACUTE DIALYSIS	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
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: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 4/10/2017 1:12 pm
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Cost Center Description		Title XIX			Hospital		PPS	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	67,026,003	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	10,450,447	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,758,333	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	12,005,238	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	25,590,827	0.000000	0.000000	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	8,771,927	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	43,940,039	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	10,677,778	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	25,097,726	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	73,244,245	0.000000	0.000000	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,705,408	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	18,318,551	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,942,792	0.000000	0.000000	0	66.00
66.01	06601	CLINICAL NUTRITION	0	32,736	0.000000	0.000000	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	2,811,288	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,004,816	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	15,676,472	0.000000	0.000000	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	805,272	0.000000	0.000000	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	230,601	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	9,269,885	0.000000	0.000000	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	19,851,514	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	45,995,349	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	1,842,206	0.000000	0.000000	0	74.00
76.00	03950	ACUTE DIALYSIS	0	5,335,421	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,821,519	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	24,667,646	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	3,479,312	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	443,353,351			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 4/10/2017 1:12 pm
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Cost Center Description		Title XIX			Hospital	PPS
		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
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	0		55.00
56.00	05600 RADIOISOTOPE	0	0	0		56.00
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
64.00	06400 INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
66.01	06601 CLINICAL NUTRITION	0	0	0		66.01
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
69.01	06901 CARDIAC REHABILITATION	0	0	0		69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
76.00	03950 ACUTE DIALYSIS	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 14-0046 Component CCN: 14-T046		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part II Date/Time Prepared: 4/10/2017 1:12 pm	
			Title XIX		Subprovider - IRF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,678,160	67,026,003	0.039957	0	0	50.00
51.00	05100	RECOVERY ROOM	31,423	10,450,447	0.003007	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	497,000	6,758,333	0.073539	0	0	52.00
53.00	05300	ANESTHESIOLOGY	42,137	12,005,238	0.003510	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,598,189	25,590,827	0.062452	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	28,600	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	69,503	8,771,927	0.007923	0	0	56.00
57.00	05700	CT SCAN	372,974	43,940,039	0.008488	0	0	57.00
58.00	05800	MRI	162,905	10,677,778	0.015256	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	460,699	25,097,726	0.018356	0	0	59.00
60.00	06000	LABORATORY	729,964	73,244,245	0.009966	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	92,698	1,705,408	0.054355	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	239,086	18,318,551	0.013052	0	0	65.00
66.00	06600	PHYSICAL THERAPY	259,866	6,942,792	0.037430	0	0	66.00
66.01	06601	CLINICAL NUTRITION	18,233	32,736	0.556971	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	211,990	2,811,288	0.075407	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	46,968	1,004,816	0.046743	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	976,621	15,676,472	0.062299	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	19,504	805,272	0.024220	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	14,039	230,601	0.060880	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	115,549	9,269,885	0.012465	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	77,245	19,851,514	0.003891	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	538,873	45,995,349	0.011716	0	0	73.00
74.00	07400	RENAL DIALYSIS	11,256	1,842,206	0.006110	0	0	74.00
76.00	03950	ACUTE DIALYSIS	84,785	5,335,421	0.015891	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	192,510	1,821,519	0.105687	0	0	90.00
91.00	09100	EMERGENCY	1,005,499	24,667,646	0.040762	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	3,479,312	0.000000	0	0	92.00
200.00		Total (lines 50-199)	10,576,276	443,353,351		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 4/10/2017 1:12 pm
Title XIX		Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
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
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601 CLINICAL NUTRITION	0	0	0	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901 CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950 ACUTE DIALYSIS	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	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: 14-0046 Component CCN: 14-T046	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 4/10/2017 1:12 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)	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	67,026,003	0.000000	0.000000		0 50.00
51.00	05100 RECOVERY ROOM	0	10,450,447	0.000000	0.000000		0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	6,758,333	0.000000	0.000000		0 52.00
53.00	05300 ANESTHESIOLOGY	0	12,005,238	0.000000	0.000000		0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	25,590,827	0.000000	0.000000		0 54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	0.000000	0.000000		0 55.00
56.00	05600 RADIOISOTOPE	0	8,771,927	0.000000	0.000000		0 56.00
57.00	05700 CT SCAN	0	43,940,039	0.000000	0.000000		0 57.00
58.00	05800 MRI	0	10,677,778	0.000000	0.000000		0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0	25,097,726	0.000000	0.000000		0 59.00
60.00	06000 LABORATORY	0	73,244,245	0.000000	0.000000		0 60.00
64.00	06400 INTRAVENOUS THERAPY	0	1,705,408	0.000000	0.000000		0 64.00
65.00	06500 RESPIRATORY THERAPY	0	18,318,551	0.000000	0.000000		0 65.00
66.00	06600 PHYSICAL THERAPY	0	6,942,792	0.000000	0.000000		0 66.00
66.01	06601 CLINICAL NUTRITION	0	32,736	0.000000	0.000000		0 66.01
67.00	06700 OCCUPATIONAL THERAPY	0	2,811,288	0.000000	0.000000		0 67.00
68.00	06800 SPEECH PATHOLOGY	0	1,004,816	0.000000	0.000000		0 68.00
69.00	06900 ELECTROCARDIOLOGY	0	15,676,472	0.000000	0.000000		0 69.00
69.01	06901 CARDIAC REHABILITATION	0	805,272	0.000000	0.000000		0 69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	230,601	0.000000	0.000000		0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	9,269,885	0.000000	0.000000		0 71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	19,851,514	0.000000	0.000000		0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	45,995,349	0.000000	0.000000		0 73.00
74.00	07400 RENAL DIALYSIS	0	1,842,206	0.000000	0.000000		0 74.00
76.00	03950 ACUTE DIALYSIS	0	5,335,421	0.000000	0.000000		0 76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	1,821,519	0.000000	0.000000		0 90.00
91.00	09100 EMERGENCY	0	24,667,646	0.000000	0.000000		0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	3,479,312	0.000000	0.000000		0 92.00
200.00	Total (lines 50-199)	0	443,353,351				0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 4/10/2017 1:12 pm
Title XIX		Subprovider - IRF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	56.00
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
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
66.01	06601 CLINICAL NUTRITION	0	0	0	66.01
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
69.01	06901 CARDIAC REHABILITATION	0	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.00	03950 ACUTE DIALYSIS	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
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: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 4/10/2017 1:12 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		28,640	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		28,640	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.		25,245	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		0	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)		14,455	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)		34,274,553	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)		34,274,553	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		40,818,066	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		40,818,066	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.839691	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)		34,274,553	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,196.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		17,298,877	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)		17,298,877	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 4/10/2017 1:12 pm	
Title XVIII			Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	7,372,926	2,749	2,682.04	1,123	3,011,931	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)					26,300,993	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					46,611,801	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)					2,539,759	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,634,952	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					5,174,711	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					41,437,090	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					3,395	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,196.74	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					4,062,932	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 4/10/2017 1:12 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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	4,115,639	34,274,553	0.120079	4,062,932	487,873	90.00
91.00	Nursing School cost	0	34,274,553	0.000000	4,062,932	0	91.00
92.00	Allied health cost	0	34,274,553	0.000000	4,062,932	0	92.00
93.00	All other Medical Education	0	34,274,553	0.000000	4,062,932	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 4/10/2017 1:12 pm
		Title XVIII	Subprovider - IRF	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)		2,195	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,195	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)		2,195	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,641	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)		2,817,719	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)		2,817,719	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)		2,817,719	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,283.70	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,106,552	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,106,552	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1	
				Component CCN: 14-T046	Date/Time Prepared: 4/10/2017 1:12 pm		
				Title XVIII	Subprovider - IRF	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,265,084		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,371,636		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)					399,616		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					126,456		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					526,072		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,845,564		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: 14-0046 Component CCN: 14-T046		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 4/10/2017 1:12 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	534,525	2,817,719	0.189701	0	0	90.00
91.00	Nursing School cost	0	2,817,719	0.000000	0	0	91.00
92.00	Allied health cost	0	2,817,719	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,817,719	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 4/10/2017 1:12 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)		28,640	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		28,640	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)		25,245	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)		4,108	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)		1,794	15.00
16.00	Nursery days (title V or XIX only)		1,265	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)		34,274,553	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)		34,274,553	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)		34,274,553	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,196.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,916,208	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)		4,916,208	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 4/10/2017 1:12 pm		
Cost Center Description			Title XIX		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	1,396,188	1,794	778.25	1,265	984,486	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	7,372,926	2,749	2,682.04	467	1,252,513	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)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,153,207	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)					830,904	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					830,904	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,322,303	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					3,395	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,196.74	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					4,062,932	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 4/10/2017 1:12 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	4,115,639	34,274,553	0.120079	4,062,932	487,873	90.00
91.00	Nursing School cost	0	34,274,553	0.000000	4,062,932	0	91.00
92.00	Allied health cost	0	34,274,553	0.000000	4,062,932	0	92.00
93.00	All other Medical Education	0	34,274,553	0.000000	4,062,932	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 4/10/2017 1:12 pm
		Title XIX	Subprovider - IRF	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)			2,195 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,195 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)			2,195 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)			283 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)			1,794 15.00
16.00	Nursery days (title V or XIX only)			1,265 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)			2,817,719 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)			2,817,719 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)			2,817,719 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,283.70 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			363,287 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)			363,287 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0046		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1	
		Component CCN: 14-T046				Date/Time Prepared: 4/10/2017 1:12 pm	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					363,287		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)					68,916		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					68,916		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					294,371		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: 14-0046 Component CCN: 14-T046		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 4/10/2017 1:12 pm	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	534,525	2,817,719	0.189701	0	0	90.00
91.00	Nursing School cost	0	2,817,719	0.000000	0	0	91.00
92.00	Allied health cost	0	2,817,719	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,817,719	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 4/10/2017 1:12 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		16,056,875	30.00
31.00	03100	INTENSIVE CARE UNIT		2,735,955	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.198541	24,915,062	50.00
51.00	05100	RECOVERY ROOM	0.085387	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.293320	1,603	52.00
53.00	05300	ANESTHESIOLOGY	0.028913	1,960,289	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.244010	5,274,946	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0.138447	0	56.00
57.00	05700	CT SCAN	0.036116	6,324,625	57.00
58.00	05800	MRI	0.074634	760,603	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.099455	5,481,264	59.00
60.00	06000	LABORATORY	0.130686	18,078,850	60.00
64.00	06400	INTRAVENOUS THERAPY	0.360881	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.152112	9,361,855	65.00
66.00	06600	PHYSICAL THERAPY	0.378157	2,374,377	66.00
66.01	06601	CLINICAL NUTRITION	11.524163	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.694212	530,399	67.00
68.00	06800	SPEECH PATHOLOGY	0.582921	141,166	68.00
69.00	06900	ELECTROCARDIOLOGY	0.192941	4,128,938	69.00
69.01	06901	CARDIAC REHABILITATION	0.470376	77,163	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.619065	87,208	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.255322	3,196,507	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.407179	7,146,494	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.279307	16,013,028	73.00
74.00	07400	RENAL DIALYSIS	0.391869	1,254,926	74.00
76.00	03950	ACUTE DIALYSIS	0.091180	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.767011	0	90.00
91.00	09100	EMERGENCY	0.292502	3,426,426	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	1.167740	230,020	92.00
200.00		Total (sum of lines 50-94 and 96-98)		110,765,749	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)		110,765,749	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 4/10/2017 1:12 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		1,540,670		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.198541	10,980	2,180	50.00
51.00	05100 RECOVERY ROOM	0.085387	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.293320	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.028913	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.244010	14,926	3,642	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.138447	0	0	56.00
57.00	05700 CT SCAN	0.036116	5,400	195	57.00
58.00	05800 MRI	0.074634	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.099455	0	0	59.00
60.00	06000 LABORATORY	0.130686	109,728	14,340	60.00
64.00	06400 INTRAVENOUS THERAPY	0.360881	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.152112	243,996	37,115	65.00
66.00	06600 PHYSICAL THERAPY	0.378157	937,865	354,660	66.00
66.01	06601 CLINICAL NUTRITION	11.524163	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.694212	936,505	650,133	67.00
68.00	06800 SPEECH PATHOLOGY	0.582921	81,726	47,640	68.00
69.00	06900 ELECTROCARDIOLOGY	0.192941	10,334	1,994	69.00
69.01	06901 CARDIAC REHABILITATION	0.470376	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.619065	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1.255322	20,419	25,632	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.407179	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.279307	279,575	78,087	73.00
74.00	07400 RENAL DIALYSIS	0.391869	0	0	74.00
76.00	03950 ACUTE DIALYSIS	0.091180	46,543	4,244	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.767011	0	0	90.00
91.00	09100 EMERGENCY	0.292502	154,605	45,222	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	1.167740	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		2,852,602	1,265,084	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)		2,852,602		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 4/10/2017 1:12 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)		22,408,676	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		7,612,004	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)		2,047,225	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)		105.60	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.53	30.00
31.00	Percentage of Medicaid patient days (see instructions)		24.26	31.00
32.00	Sum of lines 30 and 31		29.79	32.00
33.00	Allowable disproportionate share percentage (see instructions)		13.79	33.00
34.00	Disproportionate share adjustment (see instructions)		1,034,963	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 4/10/2017 1:12 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)		0.000143352	0.000148135	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		918,331	885,476	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		687,494	223,189	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		910,683		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)		34,013,551		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)			34,013,551	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			2,844,710	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			3,659	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)			36,861,920	59.00
60.00	Primary payer payments			9,575	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			36,852,345	61.00
62.00	Deductibles billed to program beneficiaries			3,235,563	62.00
63.00	Coinurance billed to program beneficiaries			52,752	63.00
64.00	Allowable bad debts (see instructions)			270,153	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			175,599	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			270,153	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			33,739,629	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)			-143,213	70.93
70.94	HRR adjustment amount (see instructions)			-250,008	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prepared: 4/10/2017 1:12 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)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			33,346,408	71.00
71.01	Sequestration adjustment (see instructions)			666,928	71.01
72.00	Interim payments			32,641,681	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)			37,799	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: 14-0046

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
4/10/2017 1:12 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	22,408,676	0	22,408,676		22,408,676	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,612,004	0		7,612,004	7,612,004	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	2,047,225	0	1,787,456	259,769	2,047,225	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1379	0.1379	0.1379	0.1379		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,034,963	0	772,539	262,424	1,034,963	11.00
11.01	Uncompensated care payments	36.00	910,683	0	910,683	0	910,683	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	34,013,551	0	25,879,354	8,134,197	34,013,551	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	34,013,551	0	25,879,354	8,134,197	34,013,551	15.00
16.00	Payment for inpatient program capital	50.00	2,844,710	0	2,163,558	681,152	2,844,710	16.00
17.00	Special add-on payments for new technologies	54.00	3,659	0	3,659	0	3,659	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0046

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
4/10/2017 1:12 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	28,046,571	8,815,349	36,861,920	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	2,395,352	0	1,783,867	611,485	2,395,352	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	449,358	0	379,691	69,667	449,358	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,844,710	0	2,163,558	681,152	2,844,710	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 14-0046		Period: From 01/01/2016 To 12/31/2016		Worksheet E Part A Exhibit 5 Date/Time Prepared: 4/10/2017 1:12 pm	
		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	22,408,676	22,408,676		22,408,676	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,612,004		7,612,004	7,612,004	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	2,047,225	1,787,456	259,769	2,047,225	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1379	0.1379	0.1379		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,034,963	772,539	262,424	1,034,963	11.00
11.01	Uncompensated care payments	36.00	910,683	687,494	0	687,494	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	34,013,551	25,879,354	8,134,197	34,013,551	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	34,013,551	25,879,354	8,134,197	34,013,551	15.00
16.00	Payment for inpatient program capital	50.00	2,844,710	2,163,558	681,152	2,844,710	16.00
17.00	Special add-on payments for new technologies	54.00	3,659	3,659	0	3,659	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			28,046,571	8,815,349	36,861,920	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Exhibit 5 Date/Time Prepared: 4/10/2017 1:12 pm
		Title XVIII	Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	2,395,352	1,783,867	611,485	2,395,352	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	449,358	379,691	69,667	449,358	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,844,710	2,163,558	681,152	2,844,710	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-143,213	-105,926	-37,287	-143,213	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-250,008	-143,439	-106,569	-250,008	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 4/10/2017 1:12 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		84,637	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		18,270,537	2.00
3.00	PPS payments		12,572,184	3.00
4.00	Outlier payment (see instructions)		294,119	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)		84,637	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		305,633	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)		305,633	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)		305,633	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		220,996	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)		84,637	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)		12,866,303	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)		2,499,951	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		10,450,989	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		10,450,989	30.00
31.00	Primary payer payments		280	31.00
32.00	Subtotal (line 30 minus line 31)		10,450,709	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)		322,365	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		209,537	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		322,365	36.00
37.00	Subtotal (see instructions)		10,660,246	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-36	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		10,660,282	40.00
40.01	Sequestration adjustment (see instructions)		213,206	40.01
41.00	Interim payments		10,336,919	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		110,157	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: 14-0046		Period: From 01/01/2016 To 12/31/2016		Worksheet E-1 Part I Date/Time Prepared: 4/10/2017 1:12 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		32,478,466		10,230,282	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		175,079		106,637	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	09/12/2016	11,864		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)		-11,864		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		32,641,681		10,336,919	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		37,799		110,157	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		32,679,480		10,447,076	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: 14-0046 Component CCN: 14-T046	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part I Date/Time Prepared: 4/10/2017 1:12 pm	
		Title XVIII	Subprovider - IRF	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				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		2,929,603		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)				0
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	09/12/2016	8,402		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)		-8,402		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)		2,921,201		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)				0
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)				0
6.01	SETTLEMENT TO PROVIDER		40,001		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		2,961,202		0
				Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				0

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0046

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

Worksheet E-1
Part II
Date/Time Prepared:
4/10/2017 1:12 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			7,667 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			15,578 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			1,330 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			27,994 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			493,435,970 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			5,482,448 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)			504,460 8.00
9.00	Sequestration adjustment amount (see instructions)			10,089 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			494,371 10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			502,495 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)			-8,124 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0046 Component CCN: 14-T046	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part III Date/Time Prepared: 4/10/2017 1:12 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			2,706,752 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0124 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			114,766 3.00
4.00	Outlier Payments			210,393 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			5.997268 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			3,031,911 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			3,031,911 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			3,031,911 19.00
20.00	Deductibles			10,276 20.00
21.00	Subtotal (line 19 minus line 20)			3,021,635 21.00
22.00	Coinsurance			0 22.00
23.00	Subtotal (line 21 minus line 22)			3,021,635 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			3,021,635 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			3,021,635 32.00
32.01	Sequestration adjustment (see instructions)			60,433 32.01
33.00	Interim payments			2,921,201 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)			40,001 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			210,393 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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)		Provider CCN: 14-0046		Period: From 01/01/2016 To 12/31/2016		Worksheet G Date/Time Prepared: 4/10/2017 1:12 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	33,343,773	0	0	0	1.00	
2.00	Temporary investments	165,937	0	0	0	2.00	
3.00	Notes receivable	0	0	0	0	3.00	
4.00	Accounts receivable	31,403,017	0	0	0	4.00	
5.00	Other receivable	2,897,357	0	0	0	5.00	
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00	
7.00	Inventory	3,990,942	0	0	0	7.00	
8.00	Prepaid expenses	3,299,200	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)	75,100,226	0	0	0	11.00	
FIXED ASSETS							
12.00	Land	632,759	0	0	0	12.00	
13.00	Land improvements	6,605,970	0	0	0	13.00	
14.00	Accumulated depreciation	-3,349,359	0	0	0	14.00	
15.00	Buildings	171,947,047	0	0	0	15.00	
16.00	Accumulated depreciation	-27,960,088	0	0	0	16.00	
17.00	Leasehold improvements	17,424,638	0	0	0	17.00	
18.00	Accumulated depreciation	-3,505,283	0	0	0	18.00	
19.00	Fixed equipment	14,823,166	0	0	0	19.00	
20.00	Accumulated depreciation	-4,145,483	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	45,376,781	0	0	0	23.00	
24.00	Accumulated depreciation	-31,164,194	0	0	0	24.00	
25.00	Minor equipment depreciable	0	0	0	0	25.00	
26.00	Accumulated depreciation	0	0	0	0	26.00	
27.00	HIT designated Assets	0	0	0	0	27.00	
28.00	Accumulated depreciation	0	0	0	0	28.00	
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00	
30.00	Total fixed assets (sum of lines 12-29)	186,685,954	0	0	0	30.00	
OTHER ASSETS							
31.00	Investments	5,040,138	0	0	0	31.00	
32.00	Deposits on leases	0	0	0	0	32.00	
33.00	Due from owners/officers	0	0	0	0	33.00	
34.00	Other assets	2,658,248	444,746	0	0	34.00	
35.00	Total other assets (sum of lines 31-34)	7,698,386	444,746	0	0	35.00	
36.00	Total assets (sum of lines 11, 30, and 35)	269,484,566	444,746	0	0	36.00	
CURRENT LIABILITIES							
37.00	Accounts payable	7,027,964	0	0	0	37.00	
38.00	Salaries, wages, and fees payable	5,508,429	0	0	0	38.00	
39.00	Payroll taxes payable	149,811	0	0	0	39.00	
40.00	Notes and loans payable (short term)	1,492,867	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	-8,448,523	0	0	0	44.00	
45.00	Total current liabilities (sum of lines 37 thru 44)	5,730,548	0	0	0	45.00	
LONG TERM LIABILITIES							
46.00	Mortgage payable	191,943,986	0	0	0	46.00	
47.00	Notes payable	0	0	0	0	47.00	
48.00	Unsecured loans	1,041,685	0	0	0	48.00	
49.00	Other long term liabilities	0	0	0	0	49.00	
50.00	Total long term liabilities (sum of lines 46 thru 49)	192,985,671	0	0	0	50.00	
51.00	Total liabilities (sum of lines 45 and 50)	198,716,219	0	0	0	51.00	
CAPITAL ACCOUNTS							
52.00	General fund balance	70,768,347				52.00	
53.00	Specific purpose fund		444,746			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)	70,768,347	444,746	0	0	59.00	
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	269,484,566	444,746	0	0	60.00	

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0046

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

Worksheet G-1

Date/Time Prepared:
4/10/2017 1:12 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		70,551,015		513,241		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		11,931,032				2.00
3.00	Total (sum of line 1 and line 2)		82,482,047		513,241		3.00
4.00	Additions	299,672		0		0	4.00
5.00	CORPORATE OFFICE	511,430		0		0	5.00
6.00	GAIN ON INVESTMENTS	0		0		0	6.00
7.00	TRANSFER FROM OTHER RELATED ORGANIZA	0		0		0	7.00
8.00	TRASFERS FROM OTHER FUNDS	8,851		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		819,953		0		10.00
11.00	Subtotal (line 3 plus line 10)		83,302,000		513,241		11.00
12.00	DEDUCTIONS (DEBIT)	0		68,495		0	12.00
13.00	CORPORATE OFFICE	0		0		0	13.00
14.00	LOSS ON INVESTMENTS	0		0		0	14.00
15.00	TRANSFER TO OTHER RELATED ORGANIZATI	12,509,854		0		0	15.00
16.00	TRANSFER TO OTHER FUNDS	0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		12,509,854		68,495		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		70,792,146		444,746		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		0				4.00
5.00	CORPORATE OFFICE		0				5.00
6.00	GAIN ON INVESTMENTS		0				6.00
7.00	TRANSFER FROM OTHER RELATED ORGANIZA		0				7.00
8.00	TRASFERS FROM OTHER FUNDS		0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	DEDUCTIONS (DEBIT)		0				12.00
13.00	CORPORATE OFFICE		0				13.00
14.00	LOSS ON INVESTMENTS		0				14.00
15.00	TRANSFER TO OTHER RELATED ORGANIZATI		0				15.00
16.00	TRANSFER TO OTHER FUNDS		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: 14-0046

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
4/10/2017 1:12 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	37,775,469		37,775,469	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	2,130,014		2,130,014	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	39,905,483		39,905,483	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,635,847		5,635,847	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	5,635,847		5,635,847	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	45,541,330		45,541,330	17.00
18.00	Ancillary services	206,264,068	222,199,590	428,463,658	18.00
19.00	Outpatient services	6,354,682	24,148,194	30,502,876	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (PRO FEES/NON REIMURSABLE)	8,276,787	3,600,501	11,877,288	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	266,436,867	249,948,285	516,385,152	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		171,016,217		29.00
30.00	OPERATING EXPENSES	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)		171,016,217		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet G-3 Date/Time Prepared: 4/10/2017 1:12 pm
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	516,385,152	1.00
2.00	Less contractual allowances and discounts on patients' accounts	341,911,023	2.00
3.00	Net patient revenues (line 1 minus line 2)	174,474,129	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	171,016,217	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,457,912	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	358,453	6.00
7.00	Income from investments	-78,651	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	4,084	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	3,995	20.00
21.00	Rental of vending machines	12,871	21.00
22.00	Rental of hospital space	175,972	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (MISC)	8,100,114	24.00
25.00	Total other income (sum of lines 6-24)	8,576,838	25.00
26.00	Total (line 5 plus line 25)	12,034,750	26.00
27.00	OTHER EXPENSES	103,718	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	103,718	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	11,931,032	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B		Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet I-5 Date/Time Prepared: 4/10/2017 1:12 pm
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		1.00	2.00	
PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B				
1.00	Total expenses related to care of program beneficiaries (see instructions)	0		1.00
2.00	Total payment due (from Wkst. 1-4, col. 6, line 11) (see instructions)	0	0	2.00
2.01	Total payment due (from Wkst. 1-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due (from Wkst. 1-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)	0	0	2.03
2.04	Outlier payments	0		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.03
4.00	Coinsurance billed to Medicare (Part B) patients	0	0	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012	0	0	5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013	0	0	5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014	0	0	5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	0	0	5.04
5.05	Total bad debts (sum of line 5 through line 5.04)	0	0	5.05
6.00	Allowable bad debts (see instructions)	0		6.00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	8.00
9.00	Program payment (see instructions)	0	0	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE				
12.00	Total allowable expenses (see instructions)	0		12.00
13.00	Total composite costs (from Wkst. 1-4, col. 2, line 11)	0		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)	0.000000		14.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0046	Period: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III Date/Time Prepared: 4/10/2017 1:12 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,395,352	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		449,358	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)		79.10	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		2,844,710	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